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No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; and THOMAS L. PERKINS, D.M.D.,

Petitioners,

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD, and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTION PRESENTED

Whether a Blue Shield plan violates section 1 of the Sherman Act by establishing and using provider-dominated committees to manipulate the terms of price competition with competing providers and to restrict the fee schedules of competing providers.

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The Pennsylvania Dental Association, eight other Pennsylvania dental societies and four individual dentists petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.[1]

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[1] The names of all parties in the proceeding below are included in the caption of the case in this Court, except for Kaye F. Thomp-

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit is reported at 745 F.2d 248 and is reprinted as Appendix A. The judgment of the United States Court of Appeals for the Third Circuit, denying the petition for rehearing *en banc*, is reprinted as Appendix C. The opinion of the District Court is reported as 547 F. Supp. 457 and is reprinted as Appendix B.

JURISDICTION

The appeal and order sought to be reviewed were entered by the United States Court of Appeals for the Third Circuit on October 1, 1984. The judgment order of the Court of Appeals sitting *en banc* was entered on November 15, 1984. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS

Section 1 of the Sherman Act, 15 U.S.C. § 1, states in relevant part:

> "Every contract, combination . . . or conspiracy in restraint of trade in commerce among the several states . . . is hereby declared to be illegal."

STATEMENT

Petitioners seek review of a decision of the United Court of Appeals for the Third Circuit upholding a decision of the United States District Court for the Middle District of Pennsylvania that dismissed an antitrust complaint. The complaint alleged, *inter alia*, that Blue Shield violated section 1 of the Sherman Act, 15 U.S.C. § 1, by empowering provider-dominated committees to injure competing providers through manipulation of the terms of price competition with those providers and

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son, D.D.S., who did not appeal the grant of summary judgment at issue here.

through restricting the fee schedules of those providers. The courts below held in essence that a Blue Shield plan can escape antitrust liability for delegating these key decisions to committees of favored medical providers simply by providing for *pro forma* ratification of the committee decisions by a board of directors.[2]

Blue Shield's prepaid dental service program in Pennsylvania purchases dental services from providers and sells them to group subscribers only. It does this through a series of provider and subscriber contracts. Dentists who choose to participate with Blue Shield enter into provider contracts that obligate them to accept a set fee from Blue Shield as their sole payment for providing services to Blue Shield subscribers. These dentists are called "participating" dentists (hereinafter "pars"). The reimbursement system establishing Blue Shield's set fee is based on the "usual, customary, and reasonable" (UCR) fees charged by Pennsylvania dentists for specific procedures. Pet. App. 6a.

Blue Shield also makes payments for services provided by dentists who do not sign provider contracts with the Blue Shield program (non-participating dentists, hereinafter "non-pars"). Non-pars do not agree to accept the Blue Shield payment as payment in full; they reserve the right to "balance bill" their patients for the difference between the Blue Shield payment and their own charges. Non-pars, unlike pars, are not paid directly by Blue Shield; payments by Blue Shield for their services go instead to the subscriber. *Ibid.*[3]

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[2] This litigation began as an action brought by the Commonwealth of Pennsylvania against nine dental associations. The associations, all of whom are petitioners herein, filed a third-party complaint against Blue Shield. Pet. App. 4a.

[3] Other differences between participating and non-participating dentists include Blue Shield's refusal to grant non-participating dentists "excepted" dental status, thereby requiring them to obtain

Blue Shield's UCR reimbursement system first makes use of a "usual charge" screen. This screen looks at the actual fees that an individual dentist charges patients for each procedure performed during a specific time period in the past (base period). These actual charges are arrayed from low to high and the usual charge screen will set the maximum Blue Shield allowance at a specific percentile (currently the 75th) of the past charges. Pet. App. 8a-9a. Regardless of a dentist's usual charge, Blue Shield will not pay more than the "customary charge." The customary charge for a particular procedure is set at a given percentile of all the usual charges of all dentists in Pennsylvania, arrayed from low to high, during a designated base period.[4] Pet. App. 9a.

Blue Shield's UCR payment allowances can obviously be increased or decreased depending on the base period selected and on the specific percentile of past charges allowed. Blue Shield has developed a guideline—the differential or performance level—for determining what specific UCR payment allowances it wants. J.A. 1357-1362.[5] The differential is simply the percentage by which the Blue Shield payment allowances to dentists in the aggregate are less than the aggregate of dentists' charges.[6]

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pre-treatment approval for certain procedures and its refusal to allow non-participating dentists to use the simpler claim forms used by pars. Pet. App. 6a, n.3.

[4] The reasonable charge screen applies only in special circumstances, *e.g.*, when a dental procedure involves complex problems that require more time by the dentist. Pet. App. 9a. It is not at issue in this petition.

[5] "J.A." references are to the Joint Appendix filed in the Court of Appeals.

[6] The payment allowance is the maximum that Blue Shield will pay a dentist for a given procedure. Under some contracts, there are certain dental procedures for which the subscriber is obligated to pay a deductible or a percentage of the allowance as a copayment.

Prior to 1975, the differential was about 2%—*i.e.*, the aggregate Blue Shield payment allowances totaled approximately 98% of aggregate charges. J.A. 2765-2770, 3294. In 1975, this differential was set by Blue Shield at 10%. J.A. 2389. In other words, Blue Shield determined that it would adjust the UCR base period and percentiles to assure that its payment allowances were 10% less than aggregate dental charges.

The differential is a key element in the price competition between participating and non-participating dentists for patients.[7] If there were no differential, and Blue Shield payments were 100% of charges, patients would have no incentive to choose pars—who accept Blue Shield payment as full payment—over non-pars who reserve the right to bill patients above the Blue Shield fee level.

As part of its reimbursement policy, Blue Shield seeks to review the fee profiles of participating and non-participating dentists to assure that the fees they charge Blue Shield subscribers are the same as they charge other patients—*i.e.*, that the fees are "usual" fees. J.A. 1267, 2395. In 1980, Blue Shield stopped updating the profile of dentists who refused to accede to an in-office review of their charges. J.A. 2396-2397. If a provider's profile is not updated, his payments from Blue Shield remain fixed despite inflation, and he is less able to compete against other dentists.

Blue Shield committees played crucial roles in the decisions with respect to both the 90% performance level (10% differential) and the freeze on dental profiles. In 1974, Blue Shield established a Dental Police Committee. J.A. 2382-2384. A majority of the committee are dentists, all of whom are participating dentists selected from

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[7] In its brief in the Third Circuit, Blue Shield acknowledged that the interest of pars and non-pars were "inherently antagonistic". It added that "requiring Blue Shield to allow dentists' full fees effectively would eliminate Blue Shield's ability to provide advantages to par doctors." Brief for Appellees 44.

among pars elected to the Blue Shield Corporation by fellow pars from throughout the state. J.A. 2716-2718. Blue Shield delegated to the Policy Committee substantial responsibility in reviewing and developing proposals relating to: review and reappraisal of current payment policies; development of guidelines for maintaining a UCR mechanism; development of guidelines for establishing fee schedule allowances; provision of guidance to enhance provider participation. Pet. App. 7a. In its third meeting, in July 1975, the committee voted on and recommended a 90% performance level or 10% differential. J.A. 2388.

In 1977, Blue Shield established a Dental Review Committe to perform the function of "peer review." This committee was empowered to resolve disputes between dentists and Blue Shield regarding fees and quality of care. This committee is also composed of a majority of dentists, all of whom are participating dentists. J.A. 1369; Pet. App. 8a. In 1979, the committee initiated the policy of freezing the fee profiles of individual dentists who refused on-site audits of their patient records. J.A. 1347, 1461, 3233. In 1980, the Blue Shield Board of Directors acknowledged that the committee had the power to freeze fee profiles without further review by Blue Shield. J.A. 2396-2397, 3233-3234. The committee has since exercised that power against some 90 dentists. J.A. 1584.

The gravamen of petitioners' complaint was a conspiracy in restraint of trade between Blue Shield and the provider members of its Dental Policy and Review Committees. Specifically, it was alleged that these committees, both dominated by participating dentists, illegally conspired and combined with Blue Shield to make decisions regarding the 10% differential and the freeze on dental profiles that injured competing providers. Pet. App. 12a. The district court and the court of appeals, ignoring this Court's teaching that summary judgment

be used sparingly in complex antitrust litigation, *Poller v. Columbia Broadcasting System*, 368 U.S. 464, 473 (1962), rejected petitioners' arguments, and granted respondents' motion for summary judgment. Pet. App. 27a, 60a-61a.

REASONS FOR GRANTING THE WRIT

1. The Anti-Competitive Actions of a Committee of Providers Established by Blue Shield Are Not Automatically Immunized from Antitrust Scrutiny Because They Are Given Pro Forma Ratification by the Blue Shield Board of Directors.

This case presents the important question whether a Blue Shield plan violates the antitrust laws by authorizing committees dominated by providers to control key policy decisions affecting the terms of price competition between those favored providers and their competitors. This issue is merely the latest embodiment of the general problem of provider control of Blue Shield plans throughout the country, which has been the subject of numerous court challenges and investigations by the Federal Trade Commission.[8] Although most Blue Shield plans have changed the structure of their Boards of Directors to eliminate overt provider domination,[9] these plans continue

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[8] See, *e.g.*, *Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981); *Ballard* v. *Blue Shield of Southern West Virginia*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977); *St. Bernard Gen. Hosp.* v. *Hospital Service Ass'n*, 712 F.2d 978 (5th Cir. 1983), *cert. denied*, 104 S. Ct. 2342 (1984); Federal Trade Commission Bureau of Competition, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* (1979); Kass & Pautler, Federal Trade Commission Bureau of Economics, *Staff Report on Physician Control of Blue Shield Plans*, FTC (1979).

[9] The national Blue Cross & Blue Shield Association now requires that, unless otherwise specified by state law, plans "maintain a governing board composed of a majority of persons other than

to make use of committees which are provider-controlled.[10] Particularly in light of Blue Shield's leading position in the health care industry, the failure of the courts below to explore the appropriate role of provider-dominated committees in the Blue Shield system requires remedy.

The legal issue presented here is whether there is an illegal conspiracy under section 1 of the Sherman Act whenever a program like Blue Shield delegates to a committee of favored medical providers the power to make key reimbursement decisions which injury competing providers, or whether the program can escape antitrust liability by maintaining the formal procedure of ratification of committee decisions by a board of directors. The Third Circuit held that even where there is strong evidence that *de facto* control rests with the provider committees, the requirement of board ratification is sufficient to terminate any claim under section 1 of a conspiracy to restrain trade by injuring a competing group of providers. This ruling is indefensible on its own merits and is inconsistent with the more realistic and sensitive approach adopted by the Fourth Circuit in *Virginia Academy of Clinicial Psychologists v. Blue Shield*, 624 F.2d 476 (1980), *cert. denied*, 450 U.S. 916 (1981), the Sixth Circuit in *Glen Eden Hospital, Inc. v. Blue Cross and Blue Shield*, 740 F.2d 423 (1984), and the FTC in several recent advisory opinions.

The essence of the decision below is captured in a single passage. After noting that one of the provider committees was not formally empowered to "approve policies for the board," and instead made policy "recommen-

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providers of health care services . . ." Blue Cross & Blue Shield Association, *Membership Standards Applicable to Regular Members* (1984).

[10] Federal Trade Commission Bureau of Competition, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* App. B (1979).

dations," the court went on to reject as irrelevant any evidence that effective control remained with the committee. It was "not impressed" with petitioners' "specific contentions" about actual control, "*including its emphasis on the statement of one Blue Shield official that he could not remember any occasion when the policy committee's recommendation was not accepted by the board.*" Pet. App. 16a-17a (emphasis added).[11] Particularly in view of the fact that the case was decided against petitioners on summary judgment, this decision stands for the proposition that, in this context, formal organizational structure makes irrelevant any evidence that competing providers are in effective control of a health plan's key reimbursement policy and peer review determinations.

The contrast with *Virginia Academy* and *Glen Eden* could not be clearer. In *Virginia Academy*, the Fourth Circuit was faced with the claim that a Blue Shield Plan had entered into a conspiracy to restrain trade with an outside group of providers, the Neuropsychiatric Society of Virginia (NSV). The court rejected this claim on the grounds that NSV policy proposals were merely suggestions that had been both accepted and rejected in the past. 624 F.2d at 483. In so doing, it enunciated a realistic standard, by holding that the plaintiffs had "failed to show that NSV had *some control* over Blue Shield's decisionmaking, or that Blue Shield *agreed to abide by* the decision of NSV in formulating its policy." *Ibid.*[12] (emphasis added.) Thus, in the context of an

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[11] The official was a long-time member and current chairman of the Board who stated that he could not recall any recommendation made by the committee that the Board did not adopt. J.A. 3219.

[12] Compare the standard enunciated for dealer-termination cases in *Monsanto Co.* v. *Spray-Rite Service Corp.*, 104 S. Ct. 1464, 1471 (1984) ("There must be evidence that tends to exclude the possibility that the manufacturer and nonterminated distributors were acting independently.")

alleged conspiracy with an outside provider group the Fourth Circuit would not be "impressed" by the fact that Blue Shield actions are formally controlled by a board, but would examine whether the outside group had some real control over those actions. There is no indication that the Fourth Circuit would apply a less flexible standard merely because the provider group is brought inside as a Blue Shield committee. Nor is there any reason, in law or logic, why it should do so.

Similarly, in *Glen Eden Hospital*, the Sixth Circuit was faced with the claim that competing hospitals had had undue control over Blue Cross's decision to demand certain payment arrangements for the plaintiff hospital and to deny all coverage to a proposed new facility to be owned by the plaintiff. The court reversed a grant of summary judgment to the defendant, calling for a more careful inquiry into whether the competing hospitals had effective "control" over Blue Cross or had "collaborated" with it. 740 F.2d at 430-31. For example, while noting that the Blue Cross Board was formerly neutral, the court considered it relevant to inquire into the "backgrounds and manner of selection of members" of that board. *Id.* at 429.

Finally, the FTC has made clear its view that, in the peer review context, it is essential to maintain the purely advisory nature of peer review committees. Such committees are often set up by medical societies to perform much the same functions for third-party payors as are performed by the Blue Shield Dental Review Committee. As discussed more fully below, the Commission has issued several recent advisory opinions approving such peer review programs on the condition that they remain truly "advisory" in substance as well as in form.

In the decision below, the Third Circuit departed drastically from these reasonable principles. The court essentially ruled that no amount of evidence of actual control by a provider committee could support a claim

of restraint of trade, as long as Blue Shield retained a requirement of formal Board ratification. And it compounded this error by improperly excluding from its analysis any discussion of the antitrust doctrine that is arguably the most applicable to the present facts—the "rule of reason." [13] Such a decision cannot be allowed to stand.

2. Supreme Court Review is Especially Important Here in View of the Sensitivity of the Particular Decisions Delegated to Provider Committees.

The full importance of the decision below can only be appreciated by looking at the specific matters effectively delegated to provider committees. These were Blue Shield policies that had the most direct impact on competition between participating dentists (the only dentists represented on either committee) and non-participating dentists.

A. *The Dental Policy Committee and the Ten Percent Differential.*

Prior to 1975, Blue Shield paid dentists on a "prevailing fee" basis, utilizing the customary charges of all dentists in the community, but not the usual charges of an individual dentist. J.A. 1761-1764. It is estimated that under this system the aggregate of Blue Shield payment allowances to all dentists equalled 98% of aggregate dental charges. J.A. 2765-2770, 3294. In insurance

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[13] Petitioners, in the court below, argued for application of the rule of *per se* illegality here and then added that, even under a rule of reason, the conduct at issue constituted an illegal restraint of trade. Brief for Appellants 35-36, 40; Tr. of Arg. 45-48. Somehow, based on these facts, the Third Circuit came to the remarkable conclusion that petitioners had "abandoned the rule of reason in this appeal." Pet. App. 11a, n.4. Contrast *St. Bernard General Hospital, Inc. v. Hospital Service Ass'n*, 712 F.2d 978, 988 (5th Cir. 1983), *cert. denied*, 104 S. Ct. 2342 (1984) ("If the requisite factors for a per se refusal to deal violation are not met, the proper course is to examine the conduct under the rule of reason rather than to dismiss the charges completely.")

parlance, this meant that Blue Shield had a 98% performance level or a 2% differential.

In late 1974, Blue Shield established the Dental Policy Committee, which, as noted above, was dominated by par dentists elected to represent fellow par dentists. In 1975, the committee voted on and recommended a 90% performance level (or 10% differential) for the new Blue Shield UCR program. J.A. 2389. Thus, aggregate Blue Shield payment allowances to dentists would be 90% of aggregate charges. The 90% performance level was later approved by the Blue Shield Board. *Ibid.*

The 90% performance level, which continues in effect to the present date, J.A. 2389, is a key element in the competition between pars and non-pars for dental patients, a competition created by the existence of a surplus of dentists. J.A. 3294-3295, 3347-3348. If there were no performance level or differential, *i.e.*, if Blue Shield paid 100% of prevailing charges, patients would have no incentive to choose pars—who accept Blue Shield payment as full payment—over non-pars—who "balance bill' patients for the difference between their charges and the Blue Shield payment.

By delegating to the Dental Policy Committee effective control over the differential, Blue Shield gave to elected representatives of pars the power to set the terms of price competition between pars and non-pars. Petitioners alleged that the committee exercised this power with the goal of improving the competitive position of pars *vis-a-vis* non-pars. The committee would do so by setting the differential at a figure large enough to create a significant incentive for patients to choose pars over non-pars, J.A. 3255-3257, but not so large that pars could no longer make money by accepting the Blue Shield allowance as payment in full.

From an antitrust standpoint, the key fact is that the calculation made by the committee of pars is very likely

to be different from that which would be made by a "neutral" decisionmaker seeking only to maximize Blue Shield's competitive position in the market of health insurers. The essence of the conspiracy alleged here was a shift of effective control from persons concerned with competition in the health insurance market to persons concerned with competition in an altogether different market—the market for dental services.[14]

Such a conspiracy plainly would violate the Sherman Act. Blue Shield has the right unilaterally to choose those from whom it will purchase services and the terms and conditions of its purchases. *United States v. Colgate & Co.*, 250 U.S. 300 (1919). If, however, a purchaser conspires with one group of sellers in order to injure, coerce, or exclude another group of sellers, its conduct violates section 1 of the Sherman Act. See *Monsanto Co. v. Spray-Rite Service Corp.*, 104 S. Ct. 1464 (1984); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36 (1977); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968); *United States v. Parke, Davis & Co.*, 362 U.S. 29 (1960).[15] Here, the group of participating "sellers" alegedly entered just

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[14] The interests of Blue Shield and the interests of the par providers are by no means identical. The pars wish to maximize revenues by establishing a Blue Shield fee level which enables them to attract patients from non-pars. That same fee level, however, may injure Blue Shield by causing subscribers who are loyal to non-pars to switch to insurance plans providing higher fee levels rather than switch to par dentists. To put it another way, par dentists may prefer to serve one hundred percent of ten thousand Blue Shield subscribers at a fee level A rather than serve seventy percent of twelve thousand subscribers at a somewhat higher fee level. But Blue Shield may be better off with the higher fee level and the greater number of subscribers. In short, pars are concerned with a different market from Blue Shield, and their domination of Blue Shield will alter the health plan's decisionmaking.

[15] Where the conspiracy is aimed at price fixing, this Court has applied a rule of *per se* illegality; in other situations, the "rule of reason" applies. *Monsanto Co.* v. *Spray-Rite Service Corp., supra*, at 1469.

such a conspiracy through the vehicle of the Policy Committee.

Of course, if the Policy Committee had merely made recommendations to Blue Shield, this would not establish a conspiracy. A group of providers may make recommendations to an insurance carriers concerning treatment of competitors without entering into a conspiracy with that carrier. *Virginia Academy of Clinical Psychologists v. Blue Shield, supra*, at 483. But in the instant case petitioners alleged that, unlike in *Virginia Academy*, the Policy Committee had *control* over Blue Shield's decision-making. The Third Circuit refused to analyze these allegations.[16] It pointedly brushed aside evidence that the

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[16] The Third Circuit stated that the goal of allowing 90% of aggragate charges was developed and urged by management. Pet. App. 17a. But the minutes of the Dental Policy Committee make clear that the suggestion as to a 90% performance level was made by Dr. Harris, a provider member of the committee. J.A. 1282. The Third Circuit also emphasized that the Policy Committee followed the recommendation of another Blue Shield committee in suggesting the 90% performance level. *Ibid.* It is true that the 90% performance level was originally suggested by the Medical Policy Committee—consisting of a majority of par physicians. J.A. 1282. But the fact that the Dental Policy Committee agreed with the approach of another provider-dominated committee does not remove the antitrust problem. Blue Shield dental and medical plans are offered separately; there was no need for identical differentials. By following the lead of the physician committee, the par dentists were establishing the terms of their price competition with non-pars.

It is also significant that the minutes of a Dental Policy Committee held after the Blue Shield Board of Directors had given its *pro forma* approval to the 90% performance level clearly indicated that management believed it was responding to the Policy Committee in adopting that level. Joseph T. Ichter, M.D., a Blue Shield Vice President, reported to the committee on the 90% performance level. The minutes state that "Both the Medical Policy Committee and the Dental Policy Committee had recommended that Management develop means to retain and/or maintain the recommended level of performance, i.e., 90% of aggregate charges.

Blue Shield Board of Directors invariably approved Policy Committee recommendations. Pet. App. 16a-17a. It ignored the fact that, unlike *Virginia Academy*, this is not a case where the provider group making recommendations is an outside organization which the insurance company (barring some form of coercion) would have no compunction rejecting. To the contrary, in this case the provider group was created and selected by the insurance company—Blue Shield—itself. It is by no means clear that Blue Shield would easily reject, or ever intended to reject, the recommendations made by a committee it created to develop "guidelines for establishing fee schedule allowances." Pet. App. 7a.

Furthermore, the court below also disregarded the significant fact that in 1975 the Blue Shield Board to which the Policy Committee made recommendations was itself dominated by participating providers. J.A. 2380.[17] Admittedly, most of these providers were not dentists, and therefore had no specific interest in the terms of competition between participating and non-participating dentists. However, as participating providers, they had a general interest in assuring participating providers a favorable position *vis-a-vis* competing non-participating providers. They therefore were particularly likely to be responsive to the recommendations from the Policy Committee. Under these circumstances, it cannot be supposed that

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In response to this charge, Dr. Ichter said that Management had prepared a January 1, 1976 update of usual . . . charges." Callahan Dep., Ex. G-6, Dist. Ct. Doc. No. 899 (emphasis added). Perhaps Dr. Ichter was simply flattering the committee and inflating its influence when he stated that management was responding to the charge of the two committees. But that cannot be determined on a motion for summary judgment.

[17] It was not until 1978 that the board of directors of Blue Shield was required by Pennsylvania statute to have fifty percent lay persons. J.A. 2380; Pet. App. 7a.

Board ratification of the committee decisions was an adequate safeguard against anticompetitive conduct.[18]

Finally, the Third Circuit's decision prevented any consideration of the *alternative* methods available to Blue Shield for determining the size of the differential between its payment allowances and aggregate dental charges. Such consideration would have highlighted the anticompetitive elements of the particular method used here. This Court pointed the way to such an analysis in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

Maricopa involved a "foundation" set up by a majority local physicians, which set maximum fees that members would charge to patients insured under certain approved health-care plans. In the course of its discussions, the Court focused on the basic policy judgment required of any insurance plan seeking to set maximum rates which doctors would accept as payment in full. Such a plan must "determine what maximum prices would be high enough to attract sufficient numbers of individual physicians to sign up but low enough to make the insurance

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[18] The Federal Trade Commission has recognized that the issue of provider control over a pre-paid health plan cannot be determined simply by examining the structure of the plan's board of directors. The Commission has stated "where a group has less than a majority of seats on a plan's governing body, the ability of the group's representatives to influence key plan decisions will be a central factor in determining the existence of control. The existence of some or all of the following factors may warrant a finding by the Commission that physician control exists: power to vote on plan reimbursement or coverage proposals; *representation on (or selection of) key plan policy-making committees (especially those dealing with reimbursement and coverage decisions)*; delegated authority, including veto or approval power, over plan policies and decisions . . . In assessing such factors, the Commission will focus on whether the physician group has, in practice, the ability to set *overall* plan policies by dominating its decision-making processes." Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* 10, n.24 (1981) (first emphasis added).

plans competitive." 457 U.S. at 353 n.28. The Court then pointed out that there was no reason why insurance companies could not obtain this information through their own canvass of physicians, rather than relying on a physician-sponsored canvass and physician fee-setting. *Ibid.*

In the instant case, Blue Shield needed to know what differential between prevailing charges and its payment allowances would achieve its goal of decreasing costs and at the same time assure both that a sufficient number of dentists agreed to be participating providers and that subscribers with loyalty to non-pars would not leave the program. Blue Shield could have relied on a canvass in this case far more easily than the insurance companies in *Maricopa*. In *Maricopa*, the insurance companies needed to find the appropriate prices for hundreds of procedures. In this case, Blue Shield simply needed to ascertain one fact—how much of a differential it could impose and still attract a sufficient number of participating dentists and subscribers. There does not appear to be any legitimate reason for giving control over this matter to a committee of providers.

In sum, the Third Circuit erred by not fully exploring the relationship between the Dental Policy Committee and Blue Shield and by not analyzing the necessity for the Policy Committee's role. If it had done so, it would have had to reach one of two conclusions. First, it could have concluded that the conspiracy shown here was *per se* illegal because it involved "price fixing." After all, the effect of the Policy Committee's action was to alter the prices paid to dentists by Blue Shield for the purpose of giving a competitive advantage to pars. This may well be enough for application of the *per se* rule. "Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se." *United States v.*

Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940). See also *Arizona v. Maricopa County Medical Society, supra.*

Alternatively, the Third Circuit would have had to analyze this conspiracy under the "rule of reason", as one aimed at a restraint of trade not directly related to prices. *Cf. Virginia Academy, supra,* at 484-486; *Continental T.V., Inc. v. GTE Sylvania Inc., supra,* 57-59. Even under the more flexible rule, Blue Shield's delegation of key decisions to the Policy Committee should be found to violate the Sherman Act.

The one thing that the Third Circuit could not properly do was to avoid any such analysis of the case by relying on the existence of formal Board ratification of the Policy Committee's action. Because of the important role that committees similar to the Policy Committee play in Blue Shield plans across the country, see note 10 *supra*, the Court should grant this writ and reverse the decision of the Third Circuit.

B. *The Dental Review Committee and the Freezing of Dentist Fee Schedules.*

In 1977, Blue Shield established a Dental Review Committee consisting of a majority of dentists, all of whom are participating dentists. J.A. 1369. The function of this committee is "peer review"—review of the procedures used and fees charged by dentists submitting bills to Blue Shield.

In late 1979, the Dental Review Committee, acting without authorization from the Blue Shield Board of Directors, began to direct Blue Shield staff to "freeze" the fee levels of dentists who had not agreed to a Blue Shield on-site audit inspection. J.A. 1347, 1461. The committee took this step despite the opposition of Blue Shield staff. J.A. 1461. In May 1980, the Blue Shield Board of Directors, at the committee's request, recognized the commitee's authority to freeze profiles when-

ever the committee deemed it appropriate without prior approval or subsequent review by the Board. J.A. 2396-2397. Since that time the committee has frozen the fees of some 90 dentists. J.A. 1584.

When the committee freezes the fee levels of a non-par, it is increasing the differential between the Blue Shield payment and the dentist's actual charge, thus improving the competitive position of par dentists. When the committee freezes the fee level of a par dentist, it is directly injuring a competitor by reducing his revenue and his ability to provide quality service.

In reviewing petitioners' challenge to the Review Committee's actions, the Third Circuit relied heavily on the fact that the Blue Shield Board of Directors had authorized these actions. But, as in the case of the Policy Committee actions, the significance of the authorization is unclear. Blue Shield's own by-laws state that "all matters, disputes or controversies arising out of the relationship between [Blue Shield] and . . . doctors of dental surgery . . . shall be considered, acted upon, *disposed of and determined by* the [Dental Review Committee]." [19] The reports of the committee to the Board are labelled "For informational purposes." J.A. 3234. In short, this appears to be a case where, in the words of *Virginia Academy*, "Blue Shield agreed to abide by the decision of [the Review Committee] in formulating its policy." 624 F.2d at 483. At the very least, it is an open question whether the Blue Shield Board of Directors made an independent decision with respect to the Review Committee's recommendation.

But even if Blue Shield were deemed to have made an independent decision regarding the profile freeze, its

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[19] Reinheimer Dep., Ex. 7, Dist. Ct. Doc. No. 709 (emphasis added). The deposition testimony of Thomas Harbold, Blue Shield staff liaison to the committee, confirmed that the Board of Directors lacked the authority not to approve the Review Committee's actions with respect to fee profiles. J.A. 3234.

decision would pose a significant antitrust problem. The Board authorized the Review Committee to freeze profiles *in individual cases* without any further review by the Board. J.A. 2396. Thus, the determinations of the Review Committee concerning the fee levels of competing providers are binding. This is enough, in itself, for respondents' peer review process to run afoul of the Sherman Act.

As noted above, decisions by the Review Committee to freeze profiles have significant negative effects on competing providers. The danger that the Review Committee will make determinations motivated in whole or in part by a desire for competitive advantage is reduced if these determinations are reviewed by a body that has no comparable competitive interest. For just this reason, the Federal Trade Commission, in three advisory opinions to provider peer review programs, has stated that the determinations of the provider committee should only be advisory to the insurance carrier.

For example, in 1982, the Commission issued an opinion approving a program of peer review of dental fees to be conducted by the Iowa Dental Association. Federal Trade Commission, *Advisory Opinion Letter to Iowa Dental Association*, 3 Trade Reg. Rep. (CCH) ¶ 22,025 (1982). In so doing, however, it emphasized that "great care must continually be taken in carrying out the program to assure that its purpose remains legitimate and that it does not produce significant anticompetitive effects." *Ibid.* The Commission continued:

> Proffered guidance given under the auspices of a major professional society can readily become coercive if the voluntary and advisory nature of the program is not perceived and sustained by all participants . . . IDA should avoid antitrust risk, therefore, by vigilantly safeguarding the voluntary and advisory nature of the fee peer review process . . . to

> prevent a lessening of price competition or innovation and to avoid unlawful coercion.

Ibid.[20]

Similarly, the Fourth Circuit in *Ratino v. Medical Service of D.C.*, 718 F.2d 1260, 1272 (1983), stated that peer review committees "undoubtedly can serve as useful mechanisms for identifying and correcting abuses in the medical profession's pricing practices, *if properly implemented and carefully monitored*." (emphasis added.) The court reversed a grant of summary judgment to the defendants, and remanded for a careful analysis of whether "under all the circumstances of the case the [peer review system] imposes an unreasonable restraint on competition." *Ibid.*

By contrast, the Third Circuit completely ignored the dangers of binding determinations by provider peer review committees. In addition to relying on the Blue Shield Board's approval of the profile freeze, the court suggested only two other reasons summary judgment on this issue was appropriate. The court noted that "the state health department has approved the concept of Blue Shield conducting in-office reviews to verify dentist's usual charges." Pet. App. 17a. But the state health department did not approve, let alone require, that determinations based on in-office reviews (or the absence of such reviews) be made in a binding manner by a committee of providers. The Fourth Circuit rejected a similar "state action" argument in *Ratino*. 718 F.2d at 1267-68. See also *California Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

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[20] See also Federal Trade Commission, *Advisory Opinion Letter to Rhode Island Professional Standards Review Organization, Inc.*, 3 Trade Reg. Rep. (CCH) ¶ 22,027 (1983); Federal Trade Commission Bureau of Competition, *Advisory Opinion Letter to the American Podiatric Ass'n* (August 18, 1983) ("[T]he voluntary and advisory nature of the program makes it unlikely that the peer review process . . . could be used either (a) to coerce the parties into adopting the policies of [the Association] or (b) to facilitate price-fixing, boycotts, or other anticompetitive conspiracies.")

The Third Circuit also noted that the "requirement that dentists certify that their fees submitted to Blue Shield have not been inflated because of insurance coverage is consistent with the ethical rules of the dental profession." Pet. App. 17a. Inflated fees raise ethical issues, and it is appropriate for Blue Shield to obtain advice from providers on this subject and then itself determine the necessary fee-related sanctions. It is not appropriate, however, for Blue Shield to permit the Review Committee to impose fee-related sanctions without any subsequent review.

Indeed, acceptance of the Third Circuit's approach would undermine any criterion—such as that proposed by the FTC—that the determination of peer review committees should not be binding on insurance carriers. Virtually every peer review determination deals with a topic —excessive fees, unnecessary treatments—which implicates professional ethical standards. But this cannot mean that peer review committees should be allowed to determine the reimbursement levels of competing providers without any review by a non-provider entity.

In sum, the Third Circuit was cavalier in concluding that the Blue Shield Board independently authorized the Review Committee's actions. In addition, the court did not address the issues raised by the binding nature of the Review Committee's determinations. It failed to heed the specific warning of the Fourth Circuit in *Ratino* that the actions of peer review committees must be "carefully monitored" and the more general warning that "the courts have had far too limited experience with such committees to hastily and generally judge their effects on competition." 718 F.2d at 1271-72.[21]

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[21] The court in *Ratino*, in contrast to the Third Circuit, see note 13 *supra*, also recognized that if the challenged peer review practices did not constitute a *per se* violation, they must then be analyzed under the rule of reason. 718 F.2d at 1272.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 84-5004

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

(*Third Party Plaintiffs*)

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

(*Third Party Defendants*)

COUNTERCLAIM DEFENDANTS

York County Dental Society, Fifth District Dental Society; Dennis W. King, D.D.S.; Charles M. Ludwig, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.; and Kay F. Thompson, D.D.S.

Pennsylvania Dental Association; Delaware Valley Dental Society; Erie County Dental Association, Inc.; Harrisburg Area Dental Society; Luzerne County Dental Society; Montgomery-Bucks Dental Society; Odontological Society of Western Pennsylvania; Scranton District Dental Society; Charles M. Ludwig, D.D.S.; Dennis W. King, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.

Appellants

Appeal from the United States District Court
for the Middle District of Pennsylvania - Scranton

(D.C. Civil No. 81-1187)

Argued August 14, 1984
Before: ALDISERT, *Chief Judge*, WEIS, *Circuit Judge*,
and RE, *Judge* *

(Filed October 1, 1984)

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* Honorable Edward D. Re, Chief Judge of the United States Court for International Trade, sitting by designation.

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OPINION OF THE COURT

ALDISERT, *Chief Judge.*

This appeal requires us to decide whether Blue Shield's prepaid dental service program in Pennsylvania violates the antitrust laws. Several Pennsylvania dental associations and individual dentists appeal from a summary judgment dismissing their antitrust and state law claims brought against the Medical Service Association of Pennsylvania, doing business as Pennsylvania Blue Shield.[1] Appellants argue that Blue Shield engaged in a price-fixing conspiracy and a group boycott in violation of § 1 of the Sherman Act, 15 U.S.C. § 1, attempted to monopolize and monopolized in violation of § 2 of the

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[1] We have jurisdiction under 28 U.S.C. § 1291 because the district court entered a final judgment certified pursuant to Rule 54(b), F. R. Civ. P. That rule provides in relevant part:

> (b) Judgment Upon Multiple Claims or Involving Multiple Parties. When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

Act, 15 U.S.C. § 2, and that the district court abused its discretion in refusing to certify a subclass of cooperating dentists for treble damages purposes. We conclude that appellants' contentions are without merit, and therefore affirm the judgment of the district court.

I.

This lawsuit is a vestige of an ill-fated action brought by the Commonwealth of Pennsylvania against nine dental associations in the state charging that they ran afoul of antitrust laws and Pennsylvania law by discouraging dentists from participating in the Blue Shield program. Essentially, the complaint accused the dentists of restraining trade under § 1 of the Sherman Act. The associations, however, countered with an antitrust action of their own, filing a third-party complaint against Blue Shield charging violations of §§ 1 and 2 of the Sherman Act, alleging that the determination of fees paid dentists by Blue Shield constitutes price fixing and a boycott, and further, that with its market power and through anticompetitive acts, Blue Shield is attempting to or is monopolizing certain relevant Pennsylvania markets and submarkets. They also asserted state law claims and requested treble damages, injunctive relief and punitive damages.

After extensive discovery, the state dismissed the Commonwealth's complaint against the associations over the objections of Blue Shield, leaving only the third-party action to survive. Blue Shield then counterclaimed against the original defendants, an additional dental society and five individual dentists, asserting a violation of § 1 of Sherman and alleging a conspiracy to boycott Blue Shield's dental programs by causing their members to terminate their participating agreements with Blue Shield, to fix charges for services paid under Blue Shield's dental program, to impede Blue Shield's cost containment efforts and to discourage dental insurance purchasers

from enrollment or continued enrollment in Blue Shield's dental programs. This counterclaim also asserted causes of action under state law including tortious interference with contractual relations, civil conspiracy and trade libel. But there was more to come. Four of the five individual dentists then filed a class action in the form of a counterclaim against Blue Shield, and, like the dental associations, alleged Sherman §§ 1 and 2 violations. Remaining are the litigants presently before us. Arrayed on one side are the Pennsylvania Dental Association, Delaware County Dental Society, Erie County Dental Association, Harrisburg Area Dental Society, Luzerne County Dental Society, Montgomery-Bucks Dental Society, Odontological Society of Western Pennsylvania, Scranton Dental Society, York County Dental Society, Dennis W. King, Charles M. Ludwig, Theodore R. Paladino, and Thomas L. Perkins. On the other side are Blue Shield and Donald S. Mayes, one of its officers, being sued in his own right.[2]

We consider in this appeal, in its Rule 54(b) context, only the summary judgment entered in favor of Blue Shield in the third-party complaint and in the class action counterclaim asserted against it. Not before us, and presumably still very much alive in the district court, is Blue Shield's counterclaim against the appellants.

II.

The controversy concerns Blue Shield's prepaid dental service program in Pennsylvania. Under that program, Blue Shield purchases dental services from providers in bulk and sells them to group subscribers only. It does this through a series of provider and subscriber contracts, covered by what is known as its Penn Dental I program. Blue Shield also markets an indemnity dental program

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[2] For the purpose of this opinion we will refer to both appellees as Blue Shield.

known as Penn Dental V. Dentists who choose to participate with Blue Shield enter into provider contracts that obligate them to accept a set fee from Blue Shield as their sole payment for providing services to Blue Shield subscribers. The reimbursement system establishing that set fee is based on the "usual, customary, and reasonable" (UCR) fees charged by Pennsylvania dentists for specific dental procedures.

Blue Shield enters into subscriber contracts with patients that provide that if covered services are obtained from a participating dentist, the subscriber will not be required to pay any additional or out-of-pocket amounts. Payment is made directly to the participating dentists by Blue Shield because participating dentists have agreed to accept the UCR fee for their services.

The subscriber contracts also cover dental services performed by dentists who do not participate in the Blue Shield program (non-participating dentists). But Blue Shield subscribers are not assured of paid-in-full service benefits if they obtain services from non-participating dentists. Blue Shield will pay only the predetermined UCR fee. Moreover, payment for non-participating dental services is made directly to the subscriber and not to the dentist.

Thus, generally speaking, the essential difference between participating dentists and non-participating dentists in the Blue Shield program is twofold: where the dentist participates, he is paid directly by Blue Shield and he agrees to accept the UCR fee as payment in full for services rendered a subscriber. Dentists who do not participate do not agree to be bound by the UCR fee; subscribers are personally responsible for any amount charged by such dentists in excess of this fee; moreover, the Blue Shield reimbursement is paid directly to the subscriber and not to the dentist.[3]

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[3] Other differences between participating and non-participating dentists include Blue Shield's refusal to grant non-participating

The thrust of appellants' price fixing complaint focuses primarily on Blue Shield's method of determining the UCR fee. It therefore becomes necessary to discuss first the relationship of participating dentists to the Blue Shield structure and second the mechanics of determining the UCR charge.

A.

Blue Shield's by-laws provide that its business shall be managed by a board of directors and that lay persons shall constitute one-half of the board. That provision is in accordance with 40 Pa. Cons. Stat. Ann. § 6328(b)(1), which requires that at least 50% of Blue Shield's board consist of lay persons. The board consists of 32 members, 16 lay persons and 16 doctors. Only two members of the board are dentists.

Standing committees of various composition exist within the Blue Shield corporate structure to consider matters referred to them by the board or management of Blue Shield. Committee members are appointed by the chairman of the board. Two of these committees, of which dentists constitute a majority, command our interest.

The Dental Policy Committee (now known as the Dental Affairs Committee) considers matters referred to it by the board or by management and forwards its recommendations to the board for approval. The specific functions and responsibilities of the policy committee include: (1) examination and determination of the validity of new dental procedures; (2) review and reappraisal of current payment policies; (3) development of guidelines for maintaining a UCR mechanism; (4) development of guidelines for establishing fee schedule allowances; (5) provision of guidance to enhance provider participation; (6) review

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dentists "excepted" dentist status, thereby requiring them to get pre-approval for new, expensive treatment, and its refusal to allow non-participating dentists to use the simpler claim forms used by participating dentists.

and reappraisal of the *Regulations for Participating Doctors*; and (7) review and appraisal of new health delivery systems. Many of these matters may reasonably be considered only by dental practitioners. Although the Blue Shield staff selects the majority of items on the committee's agenda, items are placed on it pursuant to requests from non-participating dentists as well as the public.

The Dental Review Committee is responsible for reviewing and making recommendations on matters affecting the status of dentists who participate in the Blue Shield program. These matters relate to conduct incompatible with participating dentist status, such as failing to verify charges with Blue Shield. The committee also considers disputes between Blue Shield and dentists involving question of professional ethics. The composition of the review committee is established pursuant to Blue Shield's by-laws in accordance with state statute, 40 Pa. Cons. Stat. Ann. § 6324(c).

B.

The parties do not dispute the mechanics of determining UCR charges. Under this system, when Blue Shield receives a bill with a dentist's fee, or charge, for a covered service, Blue Shield does not automatically allow payment of the full charge. Rather, the "allowance" may be different from the dentist's fee because of the operation of the three separate "screens" or artificial calculations—usual, customary, and reasonable.

The "usual charge" screen looks at the fees that an individual dentist most frequently charges patients for the procedure performed (*e.g.*, a particular type of filling or crown) during a specific time period in the past (base period). These usual charges (sometimes referred to as a dentist's profile) range from low to high, and the "usual charge" screen will set the maximum allowance at a spe-

cific percentile of the past charges. Since 1979, Blue Shield's usual charge screen has been the 75th percentile.

The "customary charge" for a particular procedure is measured as a function of all the "usual charges" of all dentists in Pennsylvania in the same speciality classification (of which there are five) during a designated base period. Since at least 1975, Blue Shield limits its allowance for any particular procedure to the 90th percentile of those charges. In recent years it has used the "usual charges" of the preceding calendar year as the base period.

The reasonable charge screen applies only in special circumstances, *e.g.*, when a dental procedure involves unique problems that require more time by the dentist. When special circumstances exist, Blue Shield might pay a larger percentage of the fee than would normally be allowed under the usual and customary charge screens. The extra allowance is determined by referring the claim to one of Blue Shield's dental advisors—a practicing dentist who works part-time for Blue Shield. The reasonable charge screen apparently is relevant to only a small percentage of claims; the usual and customary charge criteria come into play much more often.

III.

It bears emphasis that the state initiated this action in 1981 by filing a complaint against the dental associations charging the associations with violating the antitrust laws by encouraging dentists to terminate their Blue Shield provider contracts. With the dispute of those particular parties behind us, and limited to a Rule 54(b) determination, we must now consider the reverse argument: whether Blue Shield has violated the federal antitrust laws.

Appellants first argue that Blue Shield engaged in a price-fixing conspiracy and an illegal group boycott in

violation of § 1 of the Sherman Act. They then argue that Blue Shield monopolized and attempted to monopolize certain Pennsylvania dental services markets in violation of § 2 of the Sherman Act. Finally, four of the individual dentist appellants argue that the district court erred in refusing to certify a subclass of cooperating dentists for treble damages purposes.

Our standard of review follows settled precepts. Because the district court rejected appellants' Sherman §§ 1 and 2 arguments on summary judgment, we must affirm if we determine that there are no disputed issues of material fact and that Blue Shield is entitled to judgment as a matter of law. *Coastal States Gas Corp. v. Department of Energy*, 644 F.2d 969, 978-79 (3d Cir. 1981). Although summary judgment should be used sparingly in complex antitrust litigation, *Poller v. Columbia Broadcasting System*, 368 U.S. 464, 473 (1962), its use is not forbidden, *see Harold Friedman, Inc. v. Kroger Co.*, 581 F.2d 1068, 1071 (3d Cir. 1978). As to the district court's refusal to certify the subclass, we must affirm in the absence of an abuse of discretion, *Wetzel v. Liberty Mutual Insurance Co.*, 508 F.2d 239, 245 (3d Cir.), *cert. denied*, 421 U.S. 1011 (1975).

IV.

As can be immediately perceived, appellants' arguments do not follow a narrow compass. They range far and wide through a thicket of antitrust law. We are required to discuss in one opinion such diverse concepts as horizontal and vertical price-fixing agreements, group boycotts, attempts to monopolize and actual monopoly in alternative markets, and, as a separate issue, the question of certifying a class action. All of this demands a discussion much more extensive and prolonged than that which we prefer to set forth in a typical decision of this court.

We turn first to appellants' restraint of trade arguments. Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States." 15 U.S.C. § 1. To establish a violation of § 1, plaintiff must show evidence of concerted action that unreasonably restrains trade. *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911). If an agreement is manifestly anticompetitive, it is conclusively presumed to be unreasonable and therefore deemed illegal *per se*. *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49-50 (1977); *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5 (1958). Otherwise, the agreement must be analyzed under the rule of reason, which requires the factfinder to determine whether, under all the circumstances of the case, the restrictive practice imposes an unreasonable restraint on competition. *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918). Essential to a finding of a § 1 violation is concerted action; unilateral action is not proscribed. *Monsanto Co. v. Spray-Rite Service Corp.*, —— U.S. —— (52 U.S.L.W. 4341, 4343, 1984); *Malley-Duff & Associates, Inc. v. Crown Life Insurance Co.*, 734 F.2d 133, 141 (3d Cir. 1984). Here, appellants argue that Blue Shield's conduct can be condemned as either illegal price-fixing or an illegal boycott, both *per se* violations of Sherman § 1.[4] We proceed to consider first appellants' price-fixing allegations and then their boycott claim.

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[4] Appellants appear to have abandoned the rule of reason in this appeal, contending instead that "The Rule of Reason Does Not Apply Here." "The District Court was wrong in applying the rule of reason at all," and "use of the rule of reason was error as a matter of law." Brief for appellants at 35, 40. Notwithstanding this express disclaimer of application of the rule of reason, appellants made further reference to the rule in their brief, arguing that the district court's rule of reason analysis, even if appropriate, was incorrect. *Id.* at 35-36, 40. Appellants discussion was so cursory, however, that this court is led to believe that appellants are not pursuing the rule of reason on appeal.

V.

To determine whether Blue Shield has engaged in illegal price-fixing, we must decide whether Blue Shield may, consistent with the Sherman Act, establish a "usual, customary, and reasonable" reimbursement system and enter into bilateral provider agreements with individual dentists that obligate them to accept that reimbursement as payment in full for their services. Appellants contend that such an arrangement is illegal *per se* because Blue Shield did not act unilaterally in setting the reimbursement formula. They maintain that those dentists participating in the Blue Shield program and competing with them conspired and acted through Blue Shield, as their agent, to establish and implement the UCR system. This argument appears to be based on a theory of structural horizontal conspiracy with a vertical link. It is dependent upon proof that participating dentists, through their majority membership on the two Blue Shield committees, actually controlled the establishment of the UCR system implemented by Blue Shield.

Appellants also contend that the arrangement with Blue Shield is illegal *per se* because the dentists did not decide independently to participate. They argue that Blue Shield economically coerced them to enter into the provider agreements and accept the UCR reimbursement formula contained therein. This argument advances a theory of vertical restraint. It is dependent upon proof that the provider agreements themselves were the product of coercion or collaboration rather than merely bilateral contracts for the sale and purchase of services at a price unilaterally fixed by the purchaser and individually agreed to by the seller. Under either theory—structural horizontal conspiracy or vertical restaint—appellants argue that the UCR reimbursement formula, the subject of concerted action, is the type of pricing restraint condemned by the *per se* rule.

The Supreme Court has held that any combination formed for the purpose and with the effect of raising, depressing, fixing, pegging or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se* under § 1 of the Sherman Act. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). Pursuant to this rule, it has condemned horizontal agreements among competitors to fix prices, *see id.*; *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980) (holding horizontal agreement among competitors to fix credit terms *per se* violation of § 1), as well as vertical resale price maintenance agreements, *see Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons*, 340 U.S. 211 (1951) (holding distillers' agreement on maximum resale price of liquor sold by distributors *per se* violations of § 1) and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) (holding publisher's establishment of maximum resale price of newspapers sold by carriers *per se* violation of § 1). These decisions make clear that the *per se* rule applies to "an agreement to fix the price to be charged in transactions with third parties, not between the contracting parties themselves." *See Sitkin Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 440, 446 (3d Cir.), *cert. denied*, 439 U.S. 866 (1978).

If we characterize the provider agreements at issue here as "merely arrangements for the purchase of goods and services by Blue Shield," *Group Health & Life Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979), Blue Shield can be viewed as a purchaser of dental services. As such, its establishment of the price it will pay the participating dentists with whom it contracts, as distinguished from the price it will charge third parties, is not price-fixing within the scope of the *per se* prohibition of § 1. *See Sitkin*, 575 F.2d at 446. Yet because Blue Shield is a purchaser that only partially reimburses the participating dentists for each sale of services, the participating dentists, in effect, are making one sale to a two-sided buyer composed of the insurer and the sub-

scriber. It is probably more accurate, therefore to characterize Blue Shield as an indemnitor or third-party payor—the ultimate payor—rather than as a purchaser. Thus, we must proceed to analyze Blue Shield's conduct under the traditional notions of horizontal and vertical price-fixing.

A.

Most recently, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Supreme Court found a medical insurance plan to be illegal *per se* as a horizontal price-fixing conspiracy. Defendants there were non-profit foundations composed of medical doctors. The member physicians, by majority vote, set maximum fees limiting the amount that they could recover as payment for services performed for patients insured under the approved insurance plans. These plans obtained foundation approval by agreeing to pay the doctors' charges up to a scheduled amount in return for the physicians' agreement to accept that amount as payment in full. The Court held that an agreement among competing physicians setting the maximum fees that may be claimed in full payment for health services provided to policyholders of specified insurance plans constitutes a *per se* violation of § 1. *Id.* at 335-36.

With respect to the case at bar and appellants' theory of horizontal conspiracy, however, there is no overt agreement among competing health care providers to establish or to fix prices as was the situation in *Maricopa*. That distinction, however, does not necessarily preclude a finding of a horizontal price fixing agreement. To the extent that Blue Shield's establishment of the UCR reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of § 1. *See United States v. Paramount Pictures, Inc.*, 334 U.S. 131 (1948); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980); *see also Maricopa*, 457 U.S. at 352

n.26 (reserving question of whether insurer, who may be under control of providers, can lawfully fix the fee schedule and enter into bilateral contracts with individual providers).

Several recent cases have dealt with a concept that seeks to prove a horizontal agreement by a theory of structural conspiracy. In *Virginia Academy*, the Fourth Circuit found that Blue Shield plans were combinations of physicians operating under the direction and control of their physician members. 624 F.2d at 481. In that case, the plans' by-laws required that a majority of the board of directors be physicians, and there was evidence in Blue Shield documents and statements tending to show physician control. In *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F. Supp. 63, 66 (E.D. Va. 1980), the court applied the "walking conspiracy" theory of *Virginia Academy* and found no provider control of Blue Cross, noting that Blue Cross's enabling statute required that a majority of a plan's board of directors be subscribers; that the board in fact had a subscriber majority, and that there was no direct evidence of member control of Blue Cross.[5]

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[5] Appellants argue that the decisions in *Glen Eden Hosital, Inc. v. Blue Cross & Blue Shield of Michigan.* —— F.2d —— (6th Cir. No. 83-1165, July 16, 1984), and *Ratino v. Medical Services of the District of Columbia (Blue Shield)*. 718 F.2d 1260 (4th Cir. 1983), which applied the "walking conspiracy" theory of *Virginia Academy*, militate in favor of finding provider control in the case at bar. We find both cases distinguishable. The Sixth Circuit in *Glen Eden* reversed the district court's conclusion that there was no provider control of Blue Cross. In *Glen Eden*, however, appellant-hospital was allowed only severely limited discovery and its requests for information directly related to the theory that participating hospitals either controlled or greatly influenced the reimbursement policy of Blue Cross were denied. For this reason, the *Glen Eden* court concluded that the grant of summary judgment was premature. In the case before us, unlike *Glen Eden*, the parties have completed extensive discovery.

In *Ratino*, the Fourth Circuit reversed a summary judgment in favor of Blue Shield. There, the district court had concluded that

We reject appellants' theory of structural horizontal conspiracy because the uncontroverted facts furnish no support for it. There is no genuine issue of material fact concerning Blue Shield's corporate and operational structure. The board of directors has the ultimate responsibility for Blue Shield's business decisions and only two members of its 32-member board are dentists. Health care providers do not constitute a majority on the board. The district court found that "[o]nly one-sixteenth of the persons responsible for making the decisions which [appellants] claim[] to be potentially and in fact anti-competitive are themselves competitors in the relevant market." Mem. op. at 15, *reprinted in* app. at 3386.

Appellants' structural conspiracy argument seems to ignore the construction of Blue Shield's board and focuses instead on the functions and composition of the review and policy committees. These facts are essentially not disputed. Admittedly, dentists constitute a majority on each of these committees. But majority membership on a committee, without more, does not make out a prima facie case of structural horizontal conspiracy. The power and the authority of that committee must be analyzed. As did the district court, we conclude that these committees were advisory only, that they were constituted and utilized as a resource to the board, that they participated in no activities anathematic to antitrust precepts, and rendered advice only when particularly solicited by the board. Appellants appear to concede that the policy committee does not approve policies for the board, but merely makes recommendations to it. We are not impressed by appellants' specific contentions in this respect, including its emphasis on the statement of one

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the UCR plan fell within the McCarran-Ferguson Act's "business of insurance" exemption, *see* 15 U.S.C. §§ 1011-1015, thereby shielding the plan from antitrust scrutiny. Holding the McCarran-Ferguson Act inapplicable, the *Ratino* court remanded the case for fact findings and a determination as to whether Blue Shield's challenged practices constitute a price-fixing conspiracy or an illegal boycott.

Blue Shield official that he could not remember any occasion when the policy committee's recommendation was not accepted by the board. Appellants argue that the committee developed, voted on, and specifically approved Blue Shield's system for calculating the customary charge screen, as well as the switch to the 10% differential (or 90% performance level) and the use of statewide classes for calculating the customary charge. But it is not controverted that the use of statewide charge classes and the goal of seeking to allow at least 90% of aggregate charges were concepts developed and urged by management. Approval of these concepts by the policy committee was simply an approval of a management decision. Nor do appellants deny that the policy committee simply followed the recommendation of another committee in suggesting the allowance of the percentage of aggregate charges reported to the dental program. Action taken to find a market price so that a purchaser-insurer does not overpay does not constitute price-fixing.

Nor do we accept the notion that the review committee participated in price-fixing when it refused to update profiles of dentists who refused to verify their usual charges pursuant to Blue Shield procedures that called for "in-office reviews" of charges. The following factors strongly militate against appellants' argument: Blue Shield's requirement that dentists certify that their fees submitted to Blue Shield have not been inflated because of insurance coverage is consistent with the ethical rules of the dental profession, Blue Shield's in-office review experience showed that about one-half of the dentists who agreed to verify their usual charges had charged inflated fees to Blue Shield and that about one-third of the dentists contacted refused to verify their usual charges, the state health department has approved the concept of Blue Shield conducting in-office reviews to verify dentists' usual charges, and profile updates were not withheld until the board of directors authorized such action.

Distilled to its essence, the question comes to this. Blue Cross, as a purchaser of or ultimate payor for dental services, sought advice on the design and operation of its dental program from committees composed primarily of practicing dentists. To give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself. We see no dispute of material fact on this issue and we conclude that there was no support for appellants' structural horizontal conspiracy argument.[6]

B.

Once appellants' horizontal theory of concerted action is eliminated, they are left with trying to prove that the provider agreements themselves evidence an unlawful vertical restraint. The Supreme Court has not condemned vertical price-fixing outside of the resale price maintenance context. *See Albrecht v. Herald Co.*, 390 U.S. 145, 151 (1968) (*resale* price fixing is a *per se* violation); *Kiefer-Stewart Co. v. Joseph Seagram & Sons*, 340 U.S. 211 (1951). As the Blue Shield provider agreements here differ greatly from the vertical arrangements to restrict resale prices invalidated in *Albrecht* and *Kiefer-Stewart*, we should be hesitant to condemn them under a *per se* rule. *See United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-08 (1972) ("[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* viola-

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[6] Appellants argue that *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982), is controlling. We disagree. In *Hydrolevel*, the Supreme Court held that standard-setting organizations may be liable under the antitrust laws for the actions of their agents committed with apparent authority. In that case, committee members had conspired to restrain trade unreasonably through a misinterpretation of the Boiler and Pressure Vessel Code. As we have concluded here, however, neither the policy nor review committees have engaged in conduct that runs afoul of the antitrust laws. Hence, there is no illegal conduct that may be imputed to Blue Shield.

tions of the Sherman Act"); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 505 (2d Cir. 1982) (holding similar provider-insurer agreements valid under *per se* rule of vertical price-fixing). Moreover, if we were to extend *Albrecht* and *Kiefer-Stewart* to the facts in this case, there would have to be evidence of some collaboration or coercion to find an unlawful price-fixing agreement. Appellants cannot prove that Blue Shield collaborated with the participating dentists unless it can prevail in its claim that the dentists really control Blue Shield. As we have already shown, this claim fails.

Appellants also advance an economic coercion conspiracy theory, arguing and Blue Shield's UCR system and administrative practices pressure dentists economically to participate. Undisputed facts give no support to this theory as a matter of law. First, Blue Shield also pays for services rendered by non-participating dentists and determines its payment allowance for services uniformly—regardless of participation status. Moreover, its dental plan covers no more than 35% of the privately insured population and purchases less than 9% of the dental care in Pennsylvania. We conclude that there is no basis for an inference that dentists are coerced to participate with Blue Shield.

VI.

We turn now to appellants' contention that Blue Shield's UCR reimbursement system and related administrative practices, as well as its Dental Plus program, constitute an illegal boycott of non-participating dentists under § 1 of the Sherman Act. Dental Plus is a Blue Shield health maintenance organization program available to U.S. Steel employees at a certain plant that involves only participating dentists. Those dentists agree to provide all covered services to certain employee subscribers in return for a fixed fee per subscriber per month.

To establish proof of an illegal boycott under § 1, a plaintiff must show "concerted action with 'a purpose either to exclude a person or group from the market, or to accomplish some other anti-competitive objective, or both.'" *Malley-Duff & Associates, Inc. v. Crown Life Insurance Co.*, 734 F.2d 133, 140 (3d Cir. 1984) (quoting *DeFilippo v. Ford Motor Co.*, 516 F.2d 1313, 1318 (3d Cir.), *cert. denied*, 423 U.S. 912 (1975)). In the context of addressing appellants' *per se* price-fixing contention, we have already demonstrated that Blue Shield's actions in setting the UCR reimbursement fee and entering into the provider agreements were purely unilateral. Accordingly, the concerted action necessary for Blue Shield to succeed with its primary boycott claim is missing, and that claim must fail.

Appellants' Dental Plus claim must also fail for lack of concerted action because there is no evidence that Blue Shield conspired with any dentists to establish Dental Plus criteria that would exclude non-participating dentists. *See Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276, 1291 (9th Cir.) ("[s]ome evidence of concerted activity directed at the alleged victims of the boycott must be offered for the case to survive summary judgment"), *cert. denied*, —— U.S. ——, 104 S.Ct. 88 (1983). Thus, as with their price-fixing claims, appellants' boycott claims fail to establish a *per se* violation under § 1. We now turn to the monopolization claims asserted under § 2 of the Sherman Act.

VII.

Appellants argue that Blue Shield violated § 2 of the Sherman Act by attempting to monopolize and monololizing the Pennsylvania market for the sale of prepaid dental care programs to group purchasers (Market I) and the Pennsylvania market for the quantity purchase of dental services (Market II).

Section 2 of the Sherman Act provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony. . . .

15 U.S.C. § 2. To establish the offense of monopolization under § 2, plaintiff must show: (1) the possession of monopoly power in the relevant geographic and product markets; and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of superior product, business acumen or historic accident. *United States v. Grinnel Corp.*, 384 U.S. 563, 570-71 (1966). The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks, *id.* at 575-76; boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand, *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056, 1063 (3d Cir.), *cert. denied*, 439 U.S. 838 (1978); *see also Larry V. Muko, Inc. v. Southwestern Pennsylvania Building & Construction Trades Council*, 670 F.2d 421, 434 (3d Cir.), *cert. denied*, 459 U.S. 916 (1982). Monopoly power is generally defined as the power to control prices or to exclude competition, *United States v. E.I. duPont de Nemours & Co.*, 351 U.S. 377 (1956), and the size of market share is a primary determinant of whether monopoly power exists, *United States v. Aluminum Co. of America (Alcoca)*, 148 F.2d 416 (2d Cir. 1945).

To establish the offense of an attempt to monopolize under § 2, plaintiff must show: (1) a specific intent to monopolize; and (2) the consequent dangerous probability of success within the relevant geographic and product markets. *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951); *Swift & Co. v. United States*, 196 U.S. 375

(1905). In proving specific intent, a mere intention to prevail over rivals or improve market position is insufficient. Even an intent to perform acts that can be objectively viewed as tending toward the acquisition of monopoly power is insufficient, unless it also appears that the acts were not "predominantly motivated by legitimate business aims." *Times Picayune Publishing Co. v. United States*, 345 U.S. 594, 627 (1953). Direct evidence of specific intent need not be shown; it may be inferred from predatory or exclusionary conduct. *Interstate Circuit, Inc. v. United States*, 306 U.S. 208 (1939); *United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 567 (E.D. Pa. 1960), *aff'd*, 365 U.S. 567 (1961).

A.

The parties agree to define Market I as the market for the statewide sale of prepaid dental services in which Blue Shield competes with a commercial insurer, Delta Dental, and other insurers. They further agree that Blue Shield's share of this market is 32-35%. The district court concluded that Blue Shield's market share was insufficient as a matter of law to establish monopolization of Market I, a conclusion appellants seem not to contest on appeal. We determine that this is entirely consistent with case law. *See Alcoa*, 148 F.2d at 424; *see also Twin City Sportservice, Inc. v. Charles O. Finley & Co.*, 512 F.2d 1264, 1274 (9th Cir. 1975). In addition, appellants' claim that Blue Shield attempted to monopolize Market I must fail as there is no evidence of specific intent. They point to the alleged § 1 violations of price-fixing and boycott as proof of this intent, but we have already rejected those claims. Absent evidence of specific intent, we need not reach the question of whether Blue Shield's market share constitutes a "dangerous probability of success."

B.

The parties disagree over the definition of Market II. Appellants define Market II as the statewide market for

the purchase of dental services in bulk pursuant to participating dentist agreements in which Blue Shield and Delta Dental are the only purchasers. They argue that in this market Blue Shield has a 91% market share. Blue Shield would define the statewide market more broadly. It contends that this market should include all purchasers of dental services in bulk, and not only Blue Shield and Delta Dental. Affidavits of chief executive officers of Blue Shield's competitors for dental insurance business and affidavits of 12 persons who arrange for the purchases of dental insurance plans for Pennsylvania businesses and companies support Blue Shield's contention that from the perspective of purchasers of dental care coverage, Blue Shield, Delta Dental, other health services corporations, and commercial carriers are all in direct competition with each other. The district court noted that appellants "present[ed] no conflicting evidence to establish a material fact in dispute," Mem. op. at 31, *reprinted in* app. at 3402. But for their part, appellants relied solely on an affidavit by Dr. Comanor, an economist, for their definition of Market II—an affidavit that expressed an opinion based on factual assumptions for which appellants cited no support in the record and that was discredited by the district court.[7]

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[7] The district court commented:

> The Comanor affidavit refers to many factual assumptions for which plaintiffs have cited no support in the record: "In the approximately 13 years that prepaid dental care and dental insurance have existed in Pennsylvania, it has become apparent that the commercial insurers are unwilling to supply programs which involve direct provider contact." (No basis for these statements and conclusions is cited,) "Moreover, while Blue Shield offers a dental indemnity program (Penndental V), this product appears to have been relatively unsuccessful in Market I." (The plaintiffs have cited no evidence to permit the characterization of an objective on the part of Penndental V to compete in plaintiffs' Market I and a lack of success in that objective.) "On this basis, there appear to be factors which limit in Market I the degree of substitutability

To put Dr. Comanor's affidavit in proper perspective, reference must be made to expert testimony and especially to Rule 703, F.R. Evid., which provides:

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in production between prepaid service benefit dental programs and dental insurance or indemnity programs." (The language, "on this basis, there appears to be factors . . ." is an inadequate foundation for the conclusion which follows.) ". . . [V]arious large employers, as well as governmental bodies and unions themselves, desire only prepaid service benefit dental programs." (No factual basis for this statement is cited.) "For these groups, who are on the buying side of Market I, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be quite low." (This statement on its face is surmise.) "Fluctuations in price will not cause them to switch from a prepaid service benefit dental program to a dental indemnity program to the extent that they are committed, whether because of union pressures or some other reason, to provide fully prepaid dental care." (There is no factual basis cited for this statement. Further, it is a conditional statement and can not on its face support the conclusion that follows.) "For other purchasers, however, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be relatively high." (This statement on its face is surmise.) "In conclusion, the cross-elasticities of supply and demand in Market I suggest that it can be viewed as a market with two distinct sub-markets." (Considering the lack of a factual basis for the propositions leading to this conclusion and the tentative nature of this statement, the conclusion is not established for purposes of this motion.)

In establishing the existence of two markets of purchasers of dental services in Pennsylvania, Dr. Comanor views the relevant issue as "whether, in response to any possible price cuts by Blue Shield or Delta Dental, dentists will shift their output from the production of pre-paid dental care to individual dental care." If so, Dr. Comanor says, these two markets would effectively be one, but if not, there are really two separate and distinct markets. Dr. Comanor then concludes that whether "dentists will shift" depends upon whether dentists are at full capacity. If the dentist is not at full capacity, Dr. Comanor says, he is not likely to shift in response to price differences and there are therefore two markets. Dr. Comanor states that, "The fact that substantial excess capacity exists

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to him at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

In *Merit Motors, Inc. v. Chrysler Corp.*, 569 F.2d 666 (D.C. Cir. 1977), the court, speaking through Judge J. Skelly Wright, emphasized that the factual predicate of an expert's opinion must find some support in the record. We agree with that court's decision and its reasoning:

> To hold that Rule 703 prevents a court from granting summary judgment against a party who relies solely on an expert's opinion that has no more basis in or out of the record than . . . theoretical speculations would seriously undermine the policies of Rule 56. We are unwilling to impose the fruitless expenses of litigation that would result from such a limitation on the power of a court to grant summary judgment.

569 F.2d at 673. We therefore agree with the district court's determination of this issue in two important respects: the Comanor affidavit did not raise an issue of material fact and, in discrediting this affidavit for lack of critical factual support, the court did not err in accepting the factual averments in Blue Shield's submissions that defined the boundaries of Market II. We also agree with the district court and conclude that appellants' monopoly argument, which hinged on their definition of Market II, must fail. Moreover, their argument that

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among Pennsylvania dentists suggests the finding of separate markets." The plaintiffs have cited no facts supporting the proposition that substantial excess capacity exists among Pennsylvania dentists.

Mem. op. at 28-30, *reprinted in* app. 3399-401.

there was an attempt to monopolize must fail on the same grounds that it failed vis-a-vis Market I.

VIII.

This brings us to the summary judgment entered in behalf of Blue Shield on the class action claim asserted by the individual dentists. According to Rule 23(a), F.R. Civ. P., a class member cannot serve as a representative party on behalf of the entire class unless, *inter alia*, he or she will "fairly and adequately protect the interests of the class." Adequate representation depends on two factors: (1) the plaintiff's attorney must be qualified, experienced, and generally able to conduct the proposed litigation: and (2) the plaintiff must not have interests antagonistic to those of the class. *Eisen v. Carlisle & Jacquelin*, 391 F.2d 555, 562 (2d Cir. 1968). Where the district court appropriately applies the criteria of Rule 23(a), it has broad discretion in determining whether the action may be maintained as a class action, and it is subject to reversal only for an abuse of that discretion. *Katz v. Carte Blanche Corp.*, 496 F.2d 747, 757 (3d Cir.) (in banc), *cert. denied*, 419 U.S. 885 (1974).

In their class action counterclaim against Blue Shield, the individual dentists alleged two distinct subclasses of dentists: (1) a subclass of cooperating dentists, consisting of participating and non-participating dentists, who accept Blue Shield's allowances as full payment for their services; and (2) a subclass of non-cooperating dentists, all non-participating dentists, who bill Blue Shield subscribers for the balance between their current fees and Blue Shield's allowances. Of the four class plaintiffs, three are non-cooperating dentists and one, Dr. King, is a cooperating one. The subclass of cooperating dentists seeks damages in the amount of the difference between Blue Shield's allowances to them and the competitive price for their services. The district court refused to

certify the subclass of cooperating dentists because (1) there are inherent conflicts between the participating and non-participating dentists, and (2) as a non-participating dentist, Dr. King cannot fairly and adequately represent the participating members of the subclass. The district court properly applied Rule 23(a) to the undisputed facts of the case and determined that Dr. King's interests, as a non-participating dentist, were antagonistic to those of participating dentists who were also part of the subclass of cooperating dentists. We cannot say that the district court abused its discretion in finding him to be an inadequate class representative and refusing to certify the subclass on that basis.

IX.

We have considered the many contentions raised by appellants. We have concluded that the district court did not err as a matter of law or impermissibly resolve any disputed issue of fact in determining that Blue Shield did not engage in an illegal price-fixing conspiracy or boycott in violation of § 1 of the Sherman Act, in determining that Blue Shield did not attempt to monopolize or monopolize in violation of § 2 of the Sherman Act, and that the district court did not abuse its discretion in refusing to certify a subclass of cooperating dentists for treble damages purposes.

The judgment of the district court will be affirmed in all respects.

A True Copy:

Teste:

Clerk of the United States Court of Appeals for the Third Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

Civil Action No. 81-1187

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

Third-Party Plaintiffs

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;

Third-Party Defendants

[Filed Oct. 28, 1983]

MEMORANDUM

The third-party defendants, Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield (hereinafter Blue Shield) and Donald S. Mayes, D.D.S., have filed a motion for summary judgment as to the claims asserted in the third amended third-party complaint (TATPC) of the third-party plaintiffs,[1] filed on

[1] The third-party plaintiffs are the Pennsylvania Dental Association (hereinafter PDA), Delaware County Dental Society, Erie

November 30, 1982. This opinion addresses that motion.

The Commonwealth of Pennsylvania initiated this civil action on October 20, 1981, by filing a complaint against the Pennsylvania Dental Association (PDA) and a number of other dental associations, contending that these associations were violating antitrust laws, principally by encouraging dentists to terminate Blue Shield participating dentist agreements. The Associations filed answers to the complaint on or about November 9, 1981.

On November 17, 1981, the Associations filed the third-party complaint at issue here naming, *inter alia*, Pennsylvania Blue Shield and Donald S. Mayes, D.D.S. as third-party defendants. Blue Shield moved to dismiss the third-party complaint on December 7, 1981. On March 1, 1982, Blue Shield's motion was denied except with respect to paragraph 12 of the third-party complaint. This third party complaint, like other pleadings in this case, has been amended a number of times.

On March 11, 1982, Blue Shield filed its answer and counterclaim to the third-party complaint naming the defendant Dental Associations and an additional Dental Association (Fifth District Dental Society) as counterclaim defendants and naming several individuals as additional defendants on the counterclaim.[2] Counterclaim defendants moved to dismiss Blue Shield's counterclaim, which motion was denied by order of July 30, 1982. On September 20, 1982, the counterclaim defendants filed a responsive pleading to Blue Shield's counterclaim, which

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County Dental Association, Inc., Harrisburg Area Dental Society, Luzerne County Dental Society, Montgomery-Bucks Dental Society, Odontological Society of Western Pennsylvania, Scranton Dental Society and York County Dental Society.

[2] On March 12, 1982, Blue Shield commenced a separate action by complaint identical to its counterclaim which was consolidated with the case at bar.

included a class action counterclaim against Blue Shield and Dr. Mayes brought by PDA and three other Dental Associations.

On September 15, 1982, Blue Shield filed a motion for a preliminary injunction. On November 17, 1982, PDA filed a motion for a preliminary injunction. On December 30, 1982, both the motions of Blue Shield and of PDA for preliminary injunctions were denied.

On November 22, 1982, the Court granted a joint motion of the Commonwealth and the Dental Associations dismissing the initial complaint on the basis of a settlement agreement.

On January 25, 1983, the class plaintiffs filed a motion for class certification. On April 6, 1983, that motion was denied in part and granted in part, the Court denying class certification completely to one subclass and certifying another subclass for injunctive relief only. That order was appealed to the Third Circuit Court of Appeals on April 13, 1983. On April 26, 1983, Blue Shield and Dr. Mayes filed a motion to dismiss the appeal and on May 24, 1983, the appeal was dismissed.

PDA is a non-profit corporation under Pennsylvania law and is an association of dentists, most of whom are licensed to practice in Pennsylvania. TATPC, 3(A), page 3. The other third-party plaintiffs (hereinafter referred to as plaintiffs) similarly are non-profit corporations composed of dentists. TATPC, 3(B-I), pages 3-5. Blue Shield is a health service corporation formed and operating under the laws of Pennsylvania. 40 P.S. § 6301 *et seq.* Dr. Mayes is a vice president in charge of dental affairs of Blue Shield.

In the third-party complaint (hereinafter referred to as the complaint), the plaintiffs allege in Count I that "since at least 1974 and continuing to the present, Blue Shield, certain Pennsylvania dentists, and other co-conspirators have been and are involved in practices which

vertically fix the price of prepaid dental care in the Commonwealth of Pennsylvania, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1." Blue Shield is alleged to fix the price of prepaid dental care vertically by use of "usual, customary and reasonable" (UCR) method of payment for services rendered by dentists to patients covered by a Blue Shield plan, and by coercing dentists who have not entered into a provider agreement with Blue Shield (pursuant to which dentists agree to accept Blue Shield's UCR-based reimbursement figure as payment in full for a given service to a patient) to charge no more than the UCR rate. TATPC, 9(A,B), pages 8-9. The plaintiffs allege that the defendants seek to coerce dentists who are not contractually obligated to charge no more than the UCR rate by having these dentists boycotted by their patients and their potential patients. TATPC, 10, pages 9-10. They allege that a Blue Shield plan known as Dental PLUS, which provides for a covered patient in the plan to receive insurance coverage for dental services only if the patient utilizes participating dentists, constitutes a boycott in violation of 15 U.S.C. § 1.

Count II of the complaint is based upon 15 U.S.C. § 2 and alleges that Blue Shield is engaged in an attempt to monopolize the "statewide (i.e., Pennsylvania) market for the provision of dental care through third-party payers" and that there is a dangerous probability that Blue Shield will succeed in its attempt. In Count II, plaintiffs aver that 1,210,000 of the 3,280,000 citizens of Pennsylvania who are covered by prepaid dental care programs are covered by Blue Shield, and that almost all dentists provide services to Blue Shield covered patients. They further aver that most dentists have signed provider agreements with Blue Shield, and that other than Blue Shield's 1,210,000 insureds there are only 90,000 insureds in Pennsylvania who are covered by prepaid dental care programs through health service corporations. They contend that Blue Shield's practices and policies described

in the first count of their complaint are prescribed or followed by Blue Shield in its effort to monopolize the statewide market for the provision of dental care through third-party payers and that this is in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

In Count III of their complaint, plaintiffs contend that Blue Shield has established an actual monopoly of a market in violation of 15 U.S.C. § 2. The relevant market, for purposes of Count III of plaintiffs' complaint, is described as, ". . . among others, the provision of prepaid dental care through health service corporations in Pennsylvania." TATPC, 33, page 18.

Count IV of the complaint charges the defendants with the state law torts of malicious abuse of civil process (for instigating the present litigation) and interference with business and contractual relationships between dentists and their patients.

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment is to be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Rule 56(e) provides that when a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleadings, but his response, by affidavits or as otherwise provided by Rule 56, must set forth specific facts showing that there is a genuine issue for trial.

Rule 401.4 of the Rules of Court for the Middle District of Pennsylvania provides:

> 401.4 Motions for Summary Judgment. Upon any motion for summary judgment pursuant to Fed.R. Civ.P. 56, there shall be annexed to the motion a separate, short and concise statement of the material

facts, in numbered paragraphs, as to which the moving party contends there is no genuine issue to be tried.

The papers opposing a motion for summary judgment shall include a separate, short and concise statement of the material facts, responding to the numbered paragraphs set forth in the statement required in the foregoing paragraph, as to which it is contended that there exists a genuine issue to be tried.

All material facts set forth in the statement required to be served by the moving party will be deemed to be admitted unless controverted by the statement required to be served by the opposing party.[3]

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[3] Rule 401.4 obviously serves an important function in connection with any summary judgment motion. It permits the Court to determine efficiently and precisely which material facts are in dispute and which are not. The rule is particularly important in a complex case like this one which involves thousands of pages of depositions, documents and other materials arguably or potentially relevant to a summary judgment motion, and involving a plethora of contentions and claims most of which the plaintiffs have not articulated with precision and clarity. Appended as Exhibit N to their motion for summary judgment, defendants have filed a statement of material facts pursuant to Rule 401.4. Appended as Exhibit F to their brief in opposition to the motion, the plaintiffs have filed a counterstatement of material facts. A review of the statements submitted by defendants and plaintiffs reveals that plaintiffs have made no reasonable effort to agree to facts that are not in dispute, and instead have caused it to appear that facts are in dispute when they are not. The Court has examined these two sets of 87 numbered paragraphs submitted by defendants and plaintiffs. In most of its numbered paragraphs, Blue Shield has set forth a clearly stated fact or set of facts. In none of PDA's corresponding paragraphs is it indicated that Blue Shield's statement is undisputed, even though many of the paragraphs can not reasonably be disputed and even though PDA frequently, in other numbered paragraphs of its own, sets forth exactly the same facts. It is confusing and serves no worthwhile purpose for purposes of Rule 56 and Local Rule 401.4 for a party opposing summary judgment to refuse to acknowledge the existence of a fact advanced by a moving party

In analyzing the defendants' motion herein, the Court will rely upon those facts set forth in defendants' Rule 401.4 statement of facts and will also accept as true those specific facts asserted by plaintiffs to be material and in dispute if the plaintiffs have pointed with clarity to evidence acceptable under Rule 56 of the Federal Rules of Civil Procedure to establish such facts. The Court will not accept plaintiffs' conclusions as to those issues which are either ultimate issues of fact or legal issues in the absence of supporting specific facts, nor will the Court accept plaintiffs' general references to entire depositions or groups of depositions as establishing specific factual points.

Blue Shield is a non-profit "professional health service corporation" operating under a state regulatory act. 40 Pa.C.S. §§ 6301-6334. It has a thirty-two member board of directors. Sixteen are lay persons and sixteen are doctors (two of whom are dentists).

The Blue Shield practices, some or all of which are alleged by the plaintiffs to constitute or assist efforts to restrain trade, to monopolize or to boycott, are set forth at length in Exhibit N to defendants' motion, and the factual descriptions of the nature of the practice are essentially not disputed in Exhibit F to plaintiff's brief.

Blue Shield's share of the market consisting of all dental prepayment plans offered by all third-party payers in Pennsylvania is no greater than 40%. Entry into the Pennsylvania dental prepayment market by health and accident insurers is unrestricted. Blue Shield purchases,

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if that fact can be established by the moving party and the opposing party has no evidence to refute it. If the asserted fact is not material, that is a matter for argument. If the asserted fact is material but the opposing party feels that additional facts relating to the same subject matter as the asserted fact are also material, the opposing party need only (by affidavits, arguments, etc.) demonstrate the existence of disputed issues of material fact.

on behalf of its subscribers, less than 9% of all of the dental care that is purchased in Pennsylvania.

A dentist may choose to become a participating dentist. A participating dentist agrees with Blue Shield to accept the Blue Shield reimbursement for a particular dental procedure as full payment for that procedure. A participating dentist is paid directly by Blue Shield. When a non-participating dentist treats a patient who is a Blue Shield subscriber, Blue Shield does not pay the dentist directly, but instead pays the subscriber the amount of the Blue Shield reimbursement. The Blue Shield reimbursement may well be less than the fee charged by the non-participating dentist.

The Blue Shield reimbursement for a particular procedure is calculated by a procedure known as the "UCR" (usual, customary and reasonable) reimbursement system. The basic rule is that a dentist is reimbursed his "usual" charge for a given dental service. The dentist's usual charge is his most frequent charge for that service.[4] However, Blue Shield has calculated a "customary" charge for each dental service, that being the ninetieth percentile of all "usual" charges for all dentists throughout Pennsylvania who practice the same specialty. Blue Shield will not ordinarily reimburse a dentist more than the "customary" charge.[5] Blue Shield subscribers are assured by this system that their covered dental services will be paid for in full if they are treated by a participat-

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[4] Blue Shield employs a formula to calculate the "usual" charge, pursuant to which the dentist's charges for a given service for the preceding calendar year and the first three months of the current calendar year are utilized. The "usual" charge is set at the seventy-fifth percentile of those charges. A listing of a dentist's usual charges for the range of services the dentist provides, so calculated, is known as the dentist's profile. Profiles are updated annually.

[5] A dentist may be reimbursed more than the customary charge upon a demonstration of special circumstances relating to the particular service provided. We believe this to be the "reasonable" element of the UCR procedure.

ing dentist. A Blue Shield subscriber is a member of a group which has contracted with Blue Shield for a prepaid dental service plan for the members of the group.

Blue Shield's ordinary contract with participating dentists requires those dentists to permit Blue Shield to inspect their books and records. Blue Shield's stated reason for this practice is to insure that reported usual charges are accurate and that Blue Shield subscribers are not charged more for a given service than other dental patients.[6] If a participating dentist does not cooperate, his profile may be frozen. Blue Shield seeks to inspect the books and records of non-participating dentists, it says, for the same reasons.[7] When a non-participating dentist refuses such an inspection, Blue Shield frequently reacts by freezing that dentist's profile. When a dentist's profile is frozen, Blue Shield will not increase the amount of reimbursement for that dentist based upon newer and higher usual charges.

The two basic elements of a cause of action under Section 1 of the Sherman Act are, first, that the defendant(s) entered into a contract, combination or conspiracy and, second, that the contract, combination or conspiracy restrains trade. *Sitkin Smelting & Refining Co. v. FMC Corp.*, 575 F.2d 400 (3d Cir. 1978); *Medical Arts Pharmacy v. Blue Cross & Blue Shield*, 518 F.Supp. 1100 (D. Conn. 1981). The United States Supreme Court, early in the history of the Sherman Act, interpreted the Section 1 prohibition to require an analysis addressed to the reason-

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[6] One of the provisions of the standard agreement between Blue Shield and a participating dentist is that the dentist will not charge a Blue Shield subscriber more than a non-subscriber for the same service.

[7] Non-participating dentists are "profiled" as to their usual charges the same as participating dentists by Blue Shield. Non-participating dentists have no agreement with Blue Shield, but Blue Shield will not reimburse a subscriber who is treated by a non-participating dentist more than that dentist's "usual" charge.

ableness of a trade restraint, since virtually all contracts can be viewed to restrain trade in some respect. *Standard Oil v. United States*, 221 U.S. 1 (1911). While some business practices, such as horizontal price fixing among competitors,[8] have been judicially determined to be unreasonable *per se* "because of their pernicious effect on competition and lack of any redeeming virtue," *Northern Pacific Railway Co. v. United States*, 356 U.S. 1 (1958), the categories of *per se* antitrust violations are narrowly and carefully defined, and most allegations that particular business practices constitute antitrust violations are to be analyzed under the "rule of reason." Under this rule, the essential analysis is whether the practice in question is anticompetitive. *See, National Society of Professional Engineers v. United States*, 435 U.S. 679, 688 (1978).

> . . . not every agreement that has an impact on price, either vertically or horizontally, is a *per se* violation of the Sherman Act. *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 23, 99 S.Ct. 1551, 1564, 60 L.Ed.2d 1 (1979). For example, a contract for the sale of goods 'fixes' the price at which the goods are to be sold, but such a contract is not *per se* illegal, absent a showing of some adverse impact on competition. *Cf. United States v. Topco Associates Inc.*, 405 U.S. 596, 606, 92 S.Ct. 1126, 1133, 31 L.Ed.2d 515 (1972); *Chicago Board of Trade v. United States*, 246 U.S. 231, 238, 38 S.Ct. 242, 243, 62 L.Ed. 683 (1918). The proper inquiry, thus, is not whether a particular agreement literally fixes a price, but whether the agreement is so 'plainly anticompetitive' and so very likely without 'redeeming virtue' that a court will apply the label '*per se* price fixing.' *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., supra*, 441 U.S., at 8-9, 99 S.Ct. at 1556-1557.

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[8] *See, Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 100 S.Ct. 1925, 64 L.Ed.2d 580 (1980).

Medical Arts Pharmacy v. Blue Cross & Blue Shield, supra, 518 F.Supp. at 1106.

The analysis of the defendants' motion must proceed with the thought in mind that summary judgment in an antitrust case is to be sparingly granted, particularly if it appears that there are factual questions presented as to the motive and intent of alleged conspirators, *Poller v. Columbia Broadcasting,* 368 U.S. 464 (1962). "Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of 'even-handed justice'." *Poller, supra,* at 473. Yet the plaintiffs, who have urged that *Poller* prevents a grant of summary judgment here, have not asked for a jury trial. The same theories which would be presented to the Court at a non-jury trial are now before the Court in the context of the motion for summary judgment. Although credibility of witnesses would be an issue for determination only at trial, this does not affect the essential theory of plaintiffs' case. There are few credibility questions presented at all by the evidence and none that is material.

An antitrust case, like any case, is subject to analysis under F.R.C.P. 56 and summary judgment is appropriate if there are no material facts in dispute.[9] Here, a study of the statement of material facts submitted by the defendants pursuant to Rule 401.4 of the Local Rules, and of the plaintiffs' corresponding statement, reveals that there are no real disputes as to the nature of the practices and policies of Blue Shield to which the Dental Associations object. The areas of contention are the effects of those practices and policies, the motivation behind them, and the proper conduct of an analysis of the relevant market.

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[9] ". . . [A]ntitrust litigation, if made immune from summary judgment, could become an anticompetitive activity itself . . . we should use summary dispositions to dispose of antitrust complaints that lack any significant supporting evidence." *Klamath-Lake Pharmaceutical Assn. v. Klamath Medical Service,* 1983-1 Trade Cases, ¶ 65,254, at page 69,507 (9th Cir. 1983).

Naturally, the threshhold inquiry in any of PDA's Section 1 claims of vertical price fixing, boycott, and horizontal price fixing is whether Blue Shield has acted in concert with participating dentists to engage in these practices. This inquiry can best be addressed by examining PDA's claim that Blue Shield has engaged in horizontal price fixing.[10]

After extensive study of this case, it becomes clear that PDA's claim against Blue Shield really depends upon PDA's ability to prove its assertion that Blue Shield "is a mere instrumentality through which certain dentists and Donald S. Mayes, D.D.S. have conspired and do conspire in violation of the Sherman Act" and "is actually a mechanism through which a conspiracy or conspiracies of participating dentists is or are effected." Brief for plaintiffs, page 2. The initial and greatest hurdle in finding that the plaintiffs have established, for summary judgment purposes, a cognizable antitrust claim, is that they have failed to clarify whether these dentists have conspired to raise dental service prices, lower them, stabilize them, or affect them in some other way. If the conspiracy is to raise prices, PDA's grievance is not economic in nature, since there is no barrier preventing any dentist from becoming a participating dentist.[11] PDA has not explained the nature of its grievance.

A price restraint established by an agreement among competitors in a service market, which tends to provide

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[10] Although not clearly expressed in the third amended third party complaint, the contention is that Blue Shield, as a "mere instrumentality" of certain dentists, has acted to maintain the price of dental care "at artificial rates." Pre-trial order of third party plaintiffs at 38. We construe this, as does Blue Shield, as a claim of horizontal price fixing, pursuant to *Arizona v. Maricopa County Medical Society, infra.*

[11] The fact that less than 9% of the dental care in Pennsylvania is purchased by Blue Shield on behalf of its subscribers looms large. The plaintiffs have made no showing or argument that the 91% of dental care for which there is not Blue Shield coverage will not seek out the lowest price for that dental care.

the same economic rewards to all practitioners regardless of their skill, experience, training, or willingness to employ innovative and difficult procedures in individual cases, violates the Sherman Act, even when the restraint is a maximum price and the competitors are physicians. *Arizona v. Maricopa County Medical Society*, 73 L.Ed.2d 48 (1982). There, a group of doctors agreed together upon maximum prices to charge for various medical services. Those doctors who participated in the plan agreed to accept no more than the maximum fee from patients who were insured under the doctors' plan. The Court held the plan to constitute a *per se* violation of the Sherman Act because it was a price-fixing scheme.

There are two principal differences between the facts of the present case and those in the *Maricopa County* case: (1) Here, there is no setting of a maximum fee, minimum fee or any fee at all. Both participating and non-participating dentists are free to independently arrive at and charge their own fee. (2) Here, there is no participation by the dentists in the setting of a maximum or minimum fee, first because there is no set fee and secondly because the UCR mechanism is established by Blue Shield which is not, like the Maricopa County Medical Society, an organization composed of practitioners.

The plaintiffs maintain that these differences are illusory. PDA claims that Blue Shield is in actuality an organization of providers or, in PDA's words, "a mechanism through which a conspiracy or conspiracies of participating providers is or are effected." PDA's argument in this regard is contradicted by the actual corporate and operational structure of Blue Shield and by the fallacies of the argument itself.[12] The fact that Blue Shield's

[12] It is important to note, since this is a motion for summary judgment, that it is not testimonial evidence that PDA relies upon to establish and advance its "conspiracy mechanism" argument. PDA does not point to conspiratorial conversations, the testimony of Blue Shield insiders or participating dentists to establish its

thirty-two member board of directors is composed of 50% lay persons and has only two dentists upon it necessarily distinguishes Blue Shield structurally from the Maricopa County Medical Society, which was composed entirely of participating providers. Only one-sixteenth of the persons responsible for making the decisions which PDA claims to be potentially and in fact anti-competitive are themselves competitors in the relevant market. The other fifteen-sixteenths of the board's members are themselves consumers of dental services whose natural interest would be in the success of Blue Shield as a health services insurer and who have not been shown to have any interest in the profitability of dentists' practices. To the extent that the plaintiffs contend, therefore, that the participating dentists and Blue Shield conspire to fix a higher price than the competitive market price, their assertion is not logical and is controverted by Blue Shield's structure. At the same time, it makes no sense to assert that the partcipating dentists conspire to fix prices that are lower than the competitive market prices. The inevitable conclusion, clearly supported by the material facts presented by this case, is that the dentists do not have control of Blue Shield.[13]

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conspiracy theory. To the extent that its theory is at all factually supported, it is on the basis of circumstantial evidence: the Blue Shield Board "rubber stamps" its committees' recommendations and the dental committees are composed of a majority of participating dentists.

[13] Our attention has been directed by PDA in a supplemental brief, to the case of *St. Bernard General Hosp. v. Hosp. Service Ass'n of New Orleans, Inc.*, 1983-2 Trade Cases ¶ 65,565 (5th Cir. 1983), as illustrative of "effective" provider control and of other points. We believe, like *Maricopa*, *St. Bernard* is factually distinguishable from the case at bar since, in *St. Bernard*, each of the nine participating hospitals appointed two representatives to Blue Shield's thirty-one member board, the remaining thirteen members being elected by the eighteen members previously appointed.

Plaintiffs also claim that the UCR mechanism does in effect set a fee, since a component part of the UCR mechanism is the state-wide "customary" fee for a particular dental service. However, the plaintiffs have presented no evidence that the "customary" element of Blue Shield's reimbursement formula has had any effect upon the fees charged either by participating or non-participating dentists in Pennsylvania. At most, they claim and could show that "UCR performance in Market II has approximated the ninety percent level each year since 1975." Brief for plaintiffs, page 16. By this, they seem to mean that the rate of reimbursement by Blue Shield for particular services to Blue Shield subscribers is, in the aggregate, approximately ninety percent of the aggregate usual charges of all reimbursed dentists for those services. That result is not the same as a maximum fee. The UCR reimbursement mechanism does not "serve to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases." Crediting PDA's theory fully, at most it can be said that a participating doctor, when treating a Blue Shield subscriber, may not realize the full benefit and value of his skill, experience, training and innovation to the extent that his fee exceeds the ninetieth percentile of statewide customary fees. This is necessarily a very limited impact upon price competition, applying as it does to only nine percent of the dental services performed statewide. As a matter of mathematical logic, it applies only to a very small percentage of those services, since only the charges of those dentists at the very upper end of the range of fees are so affected. In any event, the impact does not result from an agreement among providers, but rather from an agreement between the individual provider and Blue Shield.

Therefore, the decision in the *Maricopa County* case does not warrant a conclusion that there is an illegal price-fixing scheme in this case. Further, as Blue Shield

has observed in its brief, this case is not factually similar to *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), where the practice of Blue Shield of Virginia was to reimburse services rendered by clinical psychologists only when those services were billed through a physician. There, the concentration of physicians (a majority)[14] on the Board of Blue Shield of Virginia, *when viewed in relationship to the practice in question*, led the Court to find the existence of an illegal horizontal arrangement. Here, the plaintiffs provided the Court with no such logical relationship between the structure of Blue Shield and any particular alleged anticompetitive results upon which to infer an antitrust violation. The plaintiffs generally claim to be aggrieved and aver that foul play is afoot, but they have failed to present facts and a cogent theory which demonstrate these claims. We conclude that this case is not governed by the *Maricopa County* case and that there is not a *per se* horizontal price-fixing violation.

Although we believe that the failure of proof of concerted action runs through PDA's other Section 1 claims, as well as the horizontal price fixing claim just discussed, we will examine each of these claims further. Provider agreements, such as those which exist between Blue Shield and participating dentists, have been scrutinized under the antitrust laws in a large number of cases. In *Group Life & Health Insurance Co. v. Royal Drug*, 440 U.S. 205 (1979), the Supreme Court established a perspective of such agreements which is important in several respects to this case. The Court held that such agreements are not within the "business of insurance" exception to the Sherman Act and characterized them as "arangements for the purchase of goods and services by [the insurer]." 440 U.S. at 214. In a number of other cases, courts have held such provider agreements to be lawful under federal anti-

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[14] Psychiatrists, who stood to gain by the practice, are physicians. Clincial psychologists are not.

trust law, and have done so in the context of motions for summary judgment. Many of these cases have involved facts very similar or analogous to those presented here. *See, Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd.*, 677 F.2d 47 (4th Cir.), *cert. den.*, 103 S.Ct. 376 (1982); *Quality Auto Body v. Allstate Insurance Co.*, 1980-2 Trade Cases ¶ 63,507 (N.D. Ill. 1980), *aff'd.*, 660 F.2d 1195 (7th Cir. 1981), *cert. den.*, 102 S.Ct. 1717 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 518 F.Supp. 1100 (D.Conn. 1981), *aff'd.*, 675 F.2d 502 (2nd Cir. 1982); *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F.Supp. 63 (E.D. Va. 1980); *Blue Cross and Blue Shield of Mich. v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cases ¶ 63,351 (E.D. Mich. 1980); *Davidowitz v. San Diego County Dental Society*, 1983-1 Trade Cases ¶ 65,231 (S.D. Cal. 1983). The view mandated by *Royal Drug*, that Blue Shield is the purchaser of dental services from the providers, is significant. Under the Sherman Act, "[t]he price fixing within the scope of the *per se* prohibition of section 1 is an agreement to fix prices to be charged in transactions with third parties, not between the contracting parties themselves." *Sitkin Smelting & Refining Co. v. F.M.C.*, 575 F.2d 440 (3d Cir. 1978).[15] There is not, in the facts presented here, any evidence of any agreement to fix prices to be charged to third parties. To the extent that Blue Shield purchases dental services on behalf of groups of subscribers, there is no evidence of any agreements between Blue Shield and providers as to Blue Shield's resale prices; i.e., Blue Shield's charges to subscribers for dental coverage.

In the absence of an agrement to fix prices to third parties and therefore of a *per se* vertical price-fixing vio-

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[15] The contentions by the plaintiffs that there is a *per se* illegal *horizontal* price-fixing scheme is considered, *infra*, pp. 19-23 under the relevant case decisions.

lation, it must be considered whether the provider agreements and other practices of Blue Shield are *intended* to fix the prices of dental services for all dental service consumers, or are intended to affect quantity or quality of dental services, *see, Sitkin, supra*; *Royal Drug, supra*; or whether there is an anticompetitive effect of the agreements and practices. This analysis must be governed by the rule of reason.

Blue Shield asserts that its UCR program is not intended to and does not in fact set prices for dental services or otherwise restrain trade, in large part because the UCR reimbursement is based upon the fee actually charged by the dentist and because each dentist is free in any event to choose not to participate. PDA's argument that the UCR program does operate to set prices for dental services is not so simply stated. It contends that in the market in which dentists sell and either individuals or third-party payors buy dental services, Blue Shield is engaged in an effort to accumulate participating dentists by causing the fees of non-participating dentists to be greater than those of participating dentists for the same services. In turn, it contends, the prices charged by participating dentists are standardized or fixed by Blue Shield by the "customary" element of the UCR system, pursuant to which reimbursements for particular charges will not exceed the customary charge for that service. Further, PDA contends, dentists are coerced by various practices of Blue Shield to become and remain participating dentists even though the reimbursement for dental services is lower than the dentists' usual fees.

PDA principally appears to contend that Blue Shield's allegedly anticompetitive practices cause Blue Shield's reimbursements to undercut the ordinary charges of PDA's member dentists, and that Blue Shield is attempting "to suppress the price of services purchased by it in

Market II [16] as well as the supply of such services." (Brief for plaintiff, page 24). However, it also repeatedly and inconsistently asserts that Blue Shield has caused an artificial increase in the price of dental services by advising participating dentists to raise prices charged to Blue Shield to counteract the effect of the inherent discount resulting from the application of Blue Shield's UCR system. If it is true that Blue Shield advises participating dentists to raise prices to "beat" the UCR system, the only conceivable artificial or wrongful inflation of prices for dental services would be felt by the uninsured patients of participating dentists. PDA has advanced no reason, and none is imaginable, why these patients would not switch to other (presumably non-participating) dentists whose prices are not artifically inflated. Therefore, PDA has not demonstrated, in opposing the summary judgment motion, that Blue Shield's practices intentionally cause non-participating dentists to become participating dentists through the elevation of non-participating dentists' prices. Moreover, the case decisions have consistently held that provider agreements that require a participating provider to accept the UCR reimbursement rate as full reimbursement do not violate the antitrust laws. *Michigan State Podiatry Ass'n. v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cases ¶ 64,801 (E.D.Mich. 1982) *Blue Cross and Blue Shield of Michigan v. Michigan Ass'n. of Psychotherapy Clinics*, 1980-2 Trade Cases ¶ 63,351 (E.D. Mich. 1980); *Sausalito Pharmacy, supra*; *Davidowitz, supra*; *Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Michigan*, 1982-83 Trade Cases ¶ 65,635 (Mich. Ct. Ap. 1982). "The failure to make more money, however, is simply not the kind of problem which the antitrust laws address." *Sausalito Pharmacy, supra*, 544 F. Supp. at 235. "The antitrust laws . . . protect com-

[16] PDA's "Market II" is defined by it as the market in which "individual dental firms sell bulk dental services to be provided directly to patients/subscribers at no cost to the latter."

petition, not competitors; and stiff competition is encouraged, not condemned." *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3d Cir.), *cert. den.*, 414 U.S. 1093 (1973). There is no significant difference presented in this case to warrant another result. PDA has not presented evidence which demonstrates that Blue Shield's practices restrain trade or eliminate competition in the market in which dentists sell, and individuals and insurers buy, dental services.

PDA's argument that Blue Shield also restrains trade by boycotting non-participating dentists and coercing or attempting to coerce dentists to become participating dentists by various practices is unconvincing. PDA contends that this occurs in part by reason of Blue Shield's refusal to make payment directly to non-participating dentists for services to Blue Shield subscribers, and by its refusal to notify these dentists that subscribers have been paid. Further, PDA alleges that Blue Shield publishes brochures "implying that non-participating dentists charge too much," [17] publishes lists of participating dentists, and permits only participating dentists to become "excepted" [18] dentists.

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[17] The instances in PDA's brief in which it states conclusory facts rather than particular facts, with extremely general citation to supporting proof or no reference at all, are legion.

[18] An "excepted" dentist is a dentist who is not routinely required by Blue Shield to submit diagnostic aides for Blue Shield's review in connection with claims for reimbursement for dental services. In 1979, Blue Shield began a practice of granting excepted dentist status only to participating dentists. It should be noted that the various practices of which complaint is made have been found acceptable by other courts. *See, e.g., Ratino v. Medical Service of District of Columbia*, 1981-1 Trade Cases, ¶ 64,144 (D. Md. 1981), (direct payment to patients of non-participating doctors only and informing subscribers of participating doctors' lower fees not a boycott); *Frankford Hospital v. Blue Cross of Greater Philadelphia*, 417 F.Supp. 1104 (E.D. Pa. 1976) (publication of lists of participating doctors not a boycott); *Quality Auto Body v. Allstate Insurance Co.*, 1980-2 Trade Cases, ¶ 63,597 (N.D. Ill. 1980), *aff'd.*,

Blue Shield's practice of not making payment directly to a non-participating dentist means simply that the non-participating dentist's payment relationship with his patient, who is a Blue Shield subscriber, is the same as his relationship with all of his other patients; that is, the dentist expects and presumably receives payment from the patient. PDA has not suggested what purpose notification to the non-participating dentist of the patient's receipt of a Blue Shield reimbursement check would serve. If it implies that dentists have collection problems, it lends support to Blue Shield's argument that to the extent that the Blue Shield UCR formula discounts some dentists' usual fees, it provides a corresponding benefit, certainty of collection. In any event, Blue Shield's practice is reasonable and pro-competitive. "Antitrust law does not condemn effective merchandising." *Human Resource Institute of Norfolk v. Blue Cross of Virginia*, 498 F. Supp. 63, at 67 (E.D. Va. 1980), citing *Travelers Insurance Co., supra*. The Court finds no evidence to support a boycott claim under Section 1 of the Sherman Act. Defendants are entitled to summary judgment as to this claim.

We turn to Counts II and III of the third-party complaint. Under Section 2 of the Sherman Act, which forms the basis for these counts of the plaintiffs' complaint, the plaintiffs would be required to establish at trial that Blue Shield possesses monopoly power in a particular market

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660 F.2d 1195 (7th Cir. 1981), *cert. denied*, —— U.S. ——, 102 S.Ct. 1717 (1982) (analog to excepted dentist classification considered reasonable business practice). We have been advised that *Ratino, supra* was reversed by the Fourth Circuit Court of Appeals on September 28, 1983. *See, Ratino v. M.S.D.C.*, 1983-2 Trade Cases ¶ 65,641. Although the reversal was based on grounds inapplicable here, the court in dicta did comment on the price fixing and other claims. Based on the thorough record before us, and the fact that this is a non-jury trial, we believe we have satisfied the analysis suggested in dicta by the court.

and that such power was willfully acquired or maintained, as distinguished from having developed as a result of a superior product, business acumen or historic accident. *United States v. Grinnell Corp.*, 384 U.S. 563, 570 (1966). To establish attempted monopolization under Section 2, plaintiffs' would need to prove a specific intent on Blue Shield's part to monopolize and a dangerous probability of success within a relevant product and geographic market. *United States v. Empire Gas Corp.*, 537 F.2d 296 (8th Cir. 1976), *cert. den.*, 429 U.S. 1122 (1977). Both offenses necessarily involve proof of a relevant market consisting of those products or services which compete with each other in the sense that they are reasonably interchangeable by consumers for the same purpose.

The plaintiffs' theory of monopolization and attempted monopolization on the part of the defendants focuses largely upon the market for the sale of prepaid dental services. As such, it is questionable whether the plaintiffs have standing to bring these Section 2 claims since it is other actual or putative sellers of prepaid dental services who would be harmed by the alleged monopolization. *See*, 15 U.S.C. § 15. However, the plaintiffs contend that they are harmed, and defendants do not directly challenge plaintiffs' standing.

In attempting to establish their claim under Section 2 of the Sherman Act, the plaintiffs rely heavily upon the affidavit of William S. Comanor, Ph.D., appended to their brief as Exhibit B. The Comanor affidavit contains a series of conclusions concerning the existence of various markets, and the role played by Blue Shield and other entities and individuals in those markets. For purposes of the pending motion, Dr. Comanor's qualifications and competence to state the opinions contained in his affidavit will be assumed. The facts upon which he bases his opinion, however, may not be assumed to exist. Rule 56 of the Federal Rules of Civil Procedure requires a nonmoving party to establish the existence of material facts

by affidavit or otherwise. To the extent that the opinions stated by Dr. Comanor are based upon facts not established in a manner provided for under Rule 56, said opinions may not be treated as establishing a material factual dispute where one would not otherwise exist.

Dr. Comanor describes two principal markets in which he considers Blue Shield to operate. Market I is the market for the sale of prepaid dental care and of dental insurance. He views prepaid dental care to be so different from dental insurance, however, that he concludes that there are two relevant sub-markets within Market I, one for the sale of prepaid dental care and one for the sale of all other forms of dental insurance. The other market that he describes, Market II, is the market for the purchase of dental services. Here, again, he finds two sub-markets, one being the market for the purchase of dental care by an individual and the other being the market for the purchase of "bulk" dental care by prepaid dental care programs, the only two of which in Pennsylvania are Blue Shield and Delta Dental.[19]

The finding that there are two separate markets in which dental services are bought and sold, coupled with the fact that Blue Shield and Delta Dental are the only two "buyers" of prepaid dental services, with Blue Shield being by far the larger of the two, permits Dr. Comanor to conclude that Blue Shield buys approximately ninety-one percent of all the commodities (prepaid dental services) sold in a particular market.

Dr. Comanor then concludes that Blue Shield has monopsony power as a buyer of prepaid dental services in Market II, which permits it to pay ten percent less for dental services provided to its subscribers than is paid

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[19] Dr. Comanor views Blue Shield as a purchaser of dental services. He does not choose to view an insurance company as a purchaser of services because it pays for dental services at a set rate rather than on a UCR basis.

for dental care provided to other persons. Monopsony power is exercised by a buyer who completely dominates a given market. Dr. Comanor is saying, in other words, that Blue Shield as a buyer in Market IIA pays less for dental care than individuals pay for dental care in Market II. Dr. Comanor does not explain how it is relevant to the existence of a monopoly that a buyer in one market pays less for a commodity than a buyer in another market pays for a different commodity.

The ultimate conclusion stated by Dr. Comanor is that "(1) Blue Shield's market share of about forty percent on the selling side of Market I understates its market power because of the high product differentiation which exists; (2) that Blue Shield has substantial monopsony power in Market II; and (3) it has exercised this power to the economic detriment of Pennsylvania dentists."

Defendants argue, in support of their motion for summary judgment as to Counts II and III of the complaint, that the plaintiffs have not adduced evidence which would permit us to define the relevant product market at issue more narrowly than the provision of prepaid dental care in Pennsylvania through all third-party payers. The Court is satisfied that this assertion is correct.

The Comanor affidavit refers to many factual assumptions for which plaintiffs have cited no support in the record. "In the approximately 13 years that prepaid dental care and dental insurance have existed in Pennsylvania, it has become apparent that the commercial insurers are unwilling to supply programs which involve direct provider contact." (No basis for these statements and conclusions is cited.) "Moreover, while Blue Shield offers a dental indemnity program (Penndental V), this product appears to have been relatively unsuccessful in Market I." (The plaintiffs have cited no evidence to permit the characterization of an objective on the part of Penndental V to compete in plaintiffs' Market I and a lack of success in that objective.) "On this basis, there

appear to be factors which limit in Market I the degree of substitutability in production between prepaid service benefit dental programs and dental insurance or indemnity programs." (The language, "on this basis, there appears to be factors . . ." is an inadequate foundation for the conclusion which follows.) ". . . [V]arious large employers, as well as governmental bodies and unions themselves, desire only prepaid service benefit dental programs." (No factual basis for this statement is cited.) "For these groups, who are on the buying side of Market I, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be quite low." (This statement on its face is surmise.) "Fluctuations in price will not cause them to switch from a prepaid service benefit dental program to a dental indemnity program to the extent that they are committed, whether because of union pressures or some other reason, to provide fully prepaid dental care." (There is no factual basis cited for this statement. Further, it is a conditional statement and can not on its face support the conclusion that follows.) "For other purchasers, however, the degree of substitutability in use between prepaid service benefit dental programs and dental indemnity programs may be relatively high." (This statement on its face is surmise.) "In conclusion, the cross-elasticities of supply and demand in Market I suggest that it can be viewed as a market with two distinct sub-markets." (Considering the lack of a factual basis for the propositions leading to this conclusion and the tentative nature of this statement, the conclusion is not established for purposes of this motion.)

In establishing the existence of two markets of purchasers of dental services in Pennsylvania, Dr. Comanor views the relevant issue as "whether, in response to any possible price cuts by Blue Shield or Delta Dental, dentists will shift their output from the production of prepaid dental care to individual dental care." If so, Dr.

Comanor says, these two markets would effectively be one, but if not, there are really two separate and distinct markets. Dr. Comanor then concludes that whether "dentists will shift" depends upon whether dentists are at full capacity. If the dentist is not at full capacity, Dr. Comanor says, he is not likely to shift in response to price differences and there are therefore two markets. Dr. Comanor states that, "The fact that substantial excess capacity exists among Pennsylvania dentists suggests the finding of separate markets." The plaintiffs have cited no facts supporting the proposition that substantial excess capacity exists among Pennsylvania dentists.

In fact, Dr. Comanor seeks to prove that there are two markets by viewing a history of participation by dentists with Blue Shield from 1975 to 1982 and by asserting that the number of participating dentists has generally increased despite the reduction of reimbursement rates by Blue Shield between 1975 and 1982 from ninety-eight percent to ninety percent.[20] He concludes that this finding can be explained by the substantial excess capacity in the production of dental services in Pennsylvania and the dentists' corresponding search for more business despite lower prices. The circular nature of Dr. Comanor's reasoning on this point is self-evident.[21]

Thus, the plaintiffs have alluded to no evidence to support the notion that Blue Shield, commercial insurance carriers and other health service corporations do not compete for the business of purchasers of dental insurance.

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[20] Of course, as already noted, these percentage figures represent averages. Blue Shield's reimbursement system compensates some dentists their full usual charge.

[21] Besides relying on a fact that has not been shown, excess capacity, Dr. Comanor's concept that dentists will or would "shift" from insured to uninsured patients, or vice-versa, seems illogical, since it is doubtful that dentists would be in a position to concentrate on one group or the other.

See, United States v. E. I. du Pont de Nemours & Co., 351 U.S. 377 (1956). Competition is to be recognized where, in fact, competition exists. *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294 (1962). The evidence cited by Blue Shield in its brief, including the deposition testimony of the chief executive officers of Blue Shield's competitors for dental insurance business, and the affidavits of twelve persons who arrange for purchases of dental insurance plans for Pennsylvania businesses and companies, establishes that from the perspective of purchasers of dental care coverage, Blue Shield and other health service corporations and commercial carriers are in direct competition. PDA presents no conflicting evidence to establish a material fact in dispute.[22] Moreover, Blue Shield's system of participating doctors and direct

[22] PDA did file, on June 24, 1983 an affidavit of John G. Milakovic, pursuant to Rule 56(f) of the Federal Rules of Civil Procedure. In the affidavit Mr. Milakovic (who is one of PDA's attorneys) testified to his belief that cross-elasticity of supply and demand between prepaid service benefit dental programs and "commercial prepaid indemnity programs" was very low. To support these contentions, Mr. Milakovic offered to depose various witnesses whom he had been "unable to contact." Mr. Milakovic estimated that three weeks would be required to complete this process. We believe the affidavit should have been accompanied by a motion, to give Blue Shield an opportunity to respond (*See* Rule 7 of the Federal Rules of Civil Procedure). Further, we do not believe the extension sought is justified. Ample time was allowed for discovery, and the discovery period has expired long ago. We find PDA's inability to support this most fundamental aspect of its case, if only by affidavits, both inexplicable and unacceptable. In a related matter, PDA has moved to strike the affidavits submitted by Blue Shield to establish cross elasticity. Blue Shield has filed a motion to strike the motion and for counsel fees. Although the affidavits contain some conclusory and inadmissible statements, they also contain useful and relevant information which we will consider. We will not strike the affidavits or selected portions of them but will instead consider them for what they are worth. The court is familiar with the rules of evidence. PDA's motion to strike will be denied as will Blue Shield's motions to strike and for counsel fees.

provider payment is not so obviously unique as to render other forms of dental plans non-competitive with Blue Shield from a potential customer's perspective. We conclude that to the extent that this case involves the market for the sale of prepaid dental coverage and an allegation by the plaintiffs of a Blue Shield monopoly in that market, said market is defined to include all prepaid service benefit dental programs and all dental insurance or indemnity programs.

Because Blue Shield's share of the market for the sale of dental coverage to consumers thereof in Pennsylvania is no greater than forty percent, it does not appear that a monopoly exists. *See, United States v. Aluminum Co. of America*, 148 F.2d 416 (2d Cir. 1945); *Twin City Sportservice, Inc. v. Charles O. Furley & Co., Inc.*, 512 F.2d 1264 (9th Cir. 1975); *Hiland Dairy, Inc. v. Krager Co.*, 402 F.2d 968, at 974 (8th Cir. 1968), *cert. den.*, 395 U.S. 961 (1969).[23] Furthermore, plaintiffs have not pointed to any real evidence which demonstrates that Blue Shield's forty percent market share permits it to have any control over the price of dental insurance or permits it to exclude competitors from the market, but instead have relied upon the highly speculative affidavit of Dr. Comanor, which itself is not based upon facts of record.

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[23] The defendants have not pursued the proposition that self-insurance should be factored into the calculation of the percentage of the sales in the relevant market made by Blue Shield. However, considering the dynamics of collective bargaining and other factors which determine whether groups of persons will have dental insurance at all or may opt for higher wages or some other benefit instead, self-insurance may be a viable competitor of Blue Shield. From the perspective of the individual purchaser of a Blue Shield plan, moreover, a resort to self-insurance may readily be chosen as an alternative to prepaid coverage if the price of prepaid coverage becomes relatively high. If self-insurance is considered, then Blue Shield's market share in the relevant market is probably 9%, the percentage of dental services that are covered by Blue Shield insurance.

Blue Shield's market share is not sufficiently large to create a dangerous probability that it can succeed in monopolizing the market for dental insurance or prepaid dental care. *See, United States v. Empire Gas Corp.*, 537 F.2d 296 (8th Cir. 1976), *cert. den.*, 429 U.S. 1122 (1977); *Nifty Foods Corp., v. Great Atlantic & Pacific Tea Co., Inc.*, 614 F.2d 832, 841 (2d Cir. 1980); *Diamond International Corp. v. Walterhoefer*, 289 F.Supp. 550, 578 (D. Md. 1968); *Hoffman v. Delta Dental Plan of Minn.*, 517 F.Supp. 564, 572 (D. Minn. 1981). Additionally, PDA has pointed to no evidence of acts, methods or plans devised or employed by Blue Shield to monopolize the market. It has not therefore pointed to evidence of a specific intent to monopolize on Blue Shield's part.

The plaintiffs seek to have us deny summary judgment and to permit the case to go to trial on the basis of a theory that is, at best, inherently inconsistent and incapable of clear, legal definition. In essence, they seek the opportunity to utilize the trial forum to pursue their case in search of its existence. A generous period of time has already been accorded plaintiffs for discovery in this case, and substantial discovery was pursued.[24] The inability of the plaintiffs at this juncture to set forth in direct and concrete terms the nature of their claims and the proof which supports them persuades us that

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[24] Specifically, by order of October 21, 1981, discovery was ordered completed by February 1, 1982, and trial was listed for February 3, 1982. The third-party complaint was filed on November 17, 1981. On February 1, 1982, at the request of PDA, the discovery deadline was extended to November 15, 1982, and trial was rescheduled to begin December 3, 1982. On August 13, 1982, the court accepted a magistrate's report recommending that the discovery deadline be extended to February 28, 1983, with trial to commence on April 4, 1983. Subsequently, on January 18, 1983, the discovery deadline was extended to April 15, 1983, and the case was moved to the June, 1983 trial list. Although further requests for extension of the discovery deadline have been refused, trial of the case has been continued a number of times, most recently pending disposition of the instant motion.

further judicial resources should not be devoted to the plaintiffs' theories, and that this case is particularly appropriate for summary judgment.

The plaintiffs also have asserted that summary judgment should be refused because there are facts in dispute as to Blue Shield's motive and intent in establishing and pursuing the various practices to which the plaintiffs object. The absence of a clear and cogent theory of the nature of Blue Shield's antitrust infraction(s) defeats this assertion. The plaintiffs have failed to state clearly even the nature of the wrongful motive and intent that they would prove, and they have certainly failed to demonstrate that they have proof to support their conclusory allegations that Blue Shield and some or all participating dentists are conspiring to fix prices and boycott non-participating dentists.

There remains for consideration the plaintiffs' claim that Blue Shield's Dental PLUS program constitutes an illegal boycott against non-participating dentists and the plaintiffs' state law claims.

The Dental PLUS program is a dental care program provided by Blue Shield that is available to those employees of United States Steel Corporation who are employed at its Fairless Hills plant, and who elect such coverage. Under Dental PLUS, a dental office which has agreed to participate in the program provides all covered dental services to the subscribers in return for a fixed fee per subscriber per month. This arrangement is variously described as a "capitation" or "health maintenance organization" concept. The employees of the steel plant are free to accept or reject participating in the program, and to date sixteen percent of the employees have elected to participate. The others receive ordinary Blue Shield UCR coverage, already considered herein. Dental PLUS providers must be Blue Shield participating dentists.

Plaintiffs argue that the Dental PLUS program amounts to an illegal boycott of those dentists who do

not participate in the program. Defendants in turn reply that there is not an actionable boycott of non-participating dentists since there is no element of coercion present with Dental PLUS and that, in any event, Dental PLUS is immune from the application of the antitrust laws because it constitutes state action. There appear to be no material facts in dispute concerning the Dental PLUS program and the merits of the plaintiffs' claim may therefore be decided under F.R.C.P. 56 at a matter of law. In view of the very limited presence of the Dental PLUS program in Pennsylvania currently, it is not conceivable that it operates in any significant way as a boycott since it affects at most, the economic interests of a small number of Pennsylvania dentists. A more meaningful evaluation of the effects of Dental PLUS could be accomplished if and when the program becomes more widespread. The Court concludes, as did the Ninth Circuit Court of Appeals in *Klamath Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 1983-1 Trade Cases, ¶ 65,254 (9th Cir. 1983), that the program at least as it presently exists in Pennsylvania, represents merely the simple exercise by Blue Shield of its freedom of contract. A solitary contract involving sixteen percent of the employees of one steel plant cannot reasonably be viewed as a boycott of all other dentists in Pennsylvania such as is prohibited by the antitrust laws. The defendants contend that, in any event, Dental PLUS constitutes state action which is exempt from the federal antitrust laws because capitation reimbursement plans such as Dental PLUS are specifically authorized and encouraged by Pennsylvania law and the Pennsylvania Departments of Health and Insurance. Because the defendants are entitled to summary judgment as to the Dental PLUS program at the Fairless Hills steel plant on the grounds that it does not constitute a boycott on the facts presented here, however, the state action exception issue need not be reached.

Count IV of the plaintiffs' complaint, which alleges clauses of action under state tort principles, will be dismissed. Jurisdiction for these state claims arises solely because they are pendent to the federal antitrust claims. Plaintiffs have made no showing of exceptional circumstances warranting our exercise of pendent jurisdiction. *See, Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., supra.*[25]

The class action counterclaim against Blue Shield and Dr. Mayes, filed on September 20, 1982, as a part of the reply of PDA and others to the third-party counterclaim of Blue Shield, must be considered in connection with our decision to grant summary judgment in favor of the third-party defendants upon the third-party complaint. The claims made in the class action counterclaim are the same as the claims in the first three counts of the third-party complaint. However, there are parties in the class action counterclaim (the members of the certified class) in addition to those in the third-party complaint. Moreover, Blue Shield and Dr. Mayes have not stated that its present motion for summary judgment is made as to the class action counterclaim as well as to the third-party complaint. It would, however, serve no valid purpose for the Court to act upon the motion for summary judgment with respect only to the third-party complaint and not with respect to the class action counterclaim when precisely the same issues are involved in both. Summary judgment therefore will be granted in favor of Blue Shield and Dr. Mayes upon both the third-party complaint and the class action counterclaim.

IT WILL BE SO ORDERED.

/s/ William W. Caldwell
WILLIAM W. CALDWELL
Date: October 28, 1983 United States District Judge

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[25] Although Blue Shield filed a motion for summary judgment on these claims, the motion was not timely since it was filed on the day of oral argument on the pending summary judgment motion.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

Civil Action No. 81-1187

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

Third-Party Plaintiffs

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;

Third-Party Defendants

ORDER

AND NOW, this 28th day of October, 1983, it is hereby ORDERED that third-party defendants' motion for summary judgment is granted as to Counts I, II and III of the third-party complaint, and judgment is hereby entered in favor of third-party defendants on these counts and against third-party plaintiffs. Count IV of the third-party complaint is dismissed. Summary judgment is hereby entered in favor of the third-party defendants in the class action counterclaim and against the third-party plaintiffs. The motion of third-party plaintiffs to strike affidavits attached as exhibits B through M of the motion for sumary judgment is denied. Third-party de-

fendants' motion to strike the aforesaid third-party plaintiffs' motion to strike and for counsel fees is denied.

This case will be placed on the April, 1984 trial list for trial of the remaining issues. A scheduling order will follow.

/s/ William W. Caldwell
WILLIAM W. CALDWELL
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

Civil Action No. 81-1187

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

Third-Party Plaintiffs

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;

Third-Party Defendants

[Filed Dec. 1, 1983]

ORDER

AND NOW, this 1st day of December, 1983, the motion of third-party and class plaintiffs for entry of final judgment and certification is GRANTED. Accordingly, we determine that there is no just reason for delay and direct that our order of October 28, 1983 granting summary judgment in favor of Pennsylvania Blue Shield and Donald S. Mayes, D.D.S. and against the third-party plaintiffs and class plaintiffs be hereby entered as a final judgment pursuant to Rule 54(b) of the Federal Rules of Civil Procedure.

/s/ William W. Caldwell
WILLIAM W. CALDWELL
United States District Judge

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 84-5004

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY ASSOCIATION; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

(Third Party Plaintiffs)

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;

(Third Party Defendants)

COUNTERCLAIM DEFENDANTS

York County Dental Society, Fifth District Dental Society, Dennis W. King, D.D.S.; Charles M. Ludwig, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.; and Kay F. Thompson, D.D.S.

Pennsylvania Dental Association; Delaware Valley Dental Society; Erie County Dental Association, Inc.; Harrisburg Area Dental Society; Luzerne County Dental Society; Montgomery-Bucks Dental Society; Odontological Society of Western Pennsylvania; Scranton District Dental Society; Charles M. Ludwig, D.D.S.; Dennis W. King, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.,

Appellants

Appeal from the United States District Court
for the Middle District of Pennsylvania—Scranton
(D.C. Civil No. 81-1187)

Present: ALDISERT, *Chief Judge*, WEIS, *Circuit Judge*, and RE, *Judge**

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the Middle District of Pennsylvania and was argued by counsel August 14, 1984.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court, entered December 1, 1983, be, and the same is hereby affirmed. Costs taxed against appellants.

ATTEST:

/s/ Sally Mroos
Clerk

October 2, 1984

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* Hon. Edward D. Re, Chief Judge of the United States Court for International Trade, sitting by designation.

APPENDIX D

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 84-5004

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE COUNTY DENTAL SOCIETY; ERIE COUNTY ASSOCIATION; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; and YORK COUNTY DENTAL SOCIETY;

(Third Party Plaintiffs)

vs.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD; and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY;

(Third Party Defendants)

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Pennsylvania Dental Association; Delaware Valley Dental Society; Erie County Dental Association, Inc.; Harrisburg Area Dental Society; Luzerne County Dental Society; Montgomery-Bucks Dental Society; Odontological Society of Western Pennsylvania; Scranton District Dental Society; Charles M. Ludwig, D.D.S.; Dennis W. King, D.D.S.; Theodore R. Paladino, D.D.S.; Thomas L. Perkins, D.M.D.,

Appellants

(M.D. Pa. Civ. No. 81-1187)

SUR PETITION FOR REHEARING

Present: ALDISERT, *Chief Judge*, SEITZ, ADAMS, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM, SLOVITER and BECKER, *Circuit Judges*, and RE, *Judge*.*

The petition for rehearing filed by appellant in the above entitled case having been submitted to the judges who participated in the decision of this court and to all other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied. Judge Gibbons would grant rehearing.

BY THE COURT,

/s/ Aldisert
Chief Judge

Dated: Nov. 15, 1984

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* Hon. Edward D. Re, Chief Judge of the United States Court for International Trade, sitting by designation.

Office - Supreme Court, U.S.
FILED
MAR 14 1985
ALEXANDER L. STEVAS
CLERK

No. 84-1296

IN THE

Supreme Court of the United States

October Term, 1984

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; and THOMAS L. PERKINS, D.M.D.,

Petitioners,

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD, and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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29 pp

QUESTION PRESENTED

Whether this Court should decline to review the Third Circuit's affirmance of summary judgment as to Section 1 Sherman Act price-fixing claims regarding Pennsylvania Blue Shield's prepaid dental program where (i) the Petitioners have presented purely fact-bound issues without any significant supporting evidence and (ii) the Third Circuit's decision is in complete conformity with the applicable decisions of this Court and with the decisions of the other United States Courts of Appeals.

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No. 84-1296

IN THE

Supreme Court of the United States

October Term, 1984

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; and THOMAS L. PERKINS, D.M.D.,

Petitioners,

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD, and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Pursuant to the authority of Rule 22 and in the manner provided by Rules 33 and 34 of the Supreme Court Rules, Medical Service Association of Pennsylvania, d/b/a Pennsylvania Blue Shield, and Donald S. Mayes, D.D.S., in his individual capacity, respond to the Petition of the Pennsylvania Dental Association, et al., and request that this Court deny the Petition on the basis of the facts and authorities hereinafter set forth for this Court's consideration.

I. STATUTORY PROVISIONS

Section 1 of the Sherman Act, 15 U.S.C. § 1, states in relevant part:

> "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is hereby declared to be illegal."

II. COUNTERSTATEMENT OF THE CASE

The Petition for a Writ of Certiorari requests a third judicial analysis of the fact-bound issue of whether participating dentists, through majority membership on two advisory committees of Pennsylvania Blue Shield (PBS), have conspired to control aspects of PBS' dental insurance program to the competitive disadvantage of dentists who do not participate with PBS. Neither the United States Court of Appeals for the Third Circuit, in its opinion by Chief Judge Aldisert, nor the District Court found any factual basis to infer the existence of such a conspiracy. Furthermore, the Third Circuit's decision does not conflict with the decisions of this Court or any federal court of appeals, nor does this case present an important question of federal antitrust law not yet settled by this Court.

The fact-bound nature of the conspiracy issue presented by the Petitioners (PDA) is evident in the Third Circuit's holding that "[w]e reject appellants' theory of structural horizontal conspiracy because the uncontroverted facts furnish no support for it." Pet. App. 16a. The District Court's rejection of PDA's horizontal conspiracy argument was even more pointed: "The plaintiffs generally claim to be aggrieved and aver that foul play is afoot, but they have failed to present facts and a cogent theory which demonstrate these claims." Pet. App. 43a.

Because the principal issue presented in PDA's Petition is one of fact and because PBS believes that PDA's Statement does not adequately describe the facts relevant to the issue presented, the following undisputed facts concerning PBS' UCR dental program are presented.

PBS' prepaid UCR dental program at issue began in 1971 and involves contracts with participating dentists (pars) who agree to accept PBS' UCR payment allowance as payment in full for services to PBS subscribers. PBS also covers services provided by dentists who do not choose to contract with PBS (nonpars). Nonpars are free to "balance bill" their PBS subscriber patients for any difference between the UCR allowance and their own charges. PBS pays pars directly; payment for nonpar services is made to the subscriber, not to the nonpar.

Both PBS' provider and subscriber contracts provide that PBS' allowance for covered services shall be determined based upon a "usual, customary and reasonable" system which is commonly referred to as UCR. Under the UCR system every charge submitted by each dentist for services to PBS' subscribers is stored on a computer.

PBS' UCR payment allowance is determined in the same manner for all dentists regardless of participation status. Under UCR an individual "usual" charge (sometimes referred to as a "profile") is calculated by PBS for each dentist, for each procedure he performs, based on the actual charges he submits. PBS also calculates a "customary" charge for each procedure, for various specialty classifications of dentists, based upon the "usual" charges calculated by PBS for the dentists within the specialty grouping. PBS' payment allowance for each procedure submitted is

the lesser of the actual submitted charge, the dentist's individual "usual" charge or the applicable customary charge.[1] Individual dentists' profiles and customary levels are generally updated annually, except in those few instances where dentists have refused to verify their usual charges.

PBS' UCR system does not set "a maximum fee, minimum fee or any fee at all." Pet. App. 40a. PBS' reimbursement to a dentist is based on the fee actually and independently charged by the dentist. The dentist, not PBS, determines his fee. PBS' UCR system is predicated on the assumption that individual dentists do not vary their fees depending on whether the patient has insurance coverage and PBS requires that dentists certify on claim forms submitted to PBS that the fees listed thereon are the fees the dentist usually charges to his private, non-insured patients for the same services. J.A. 317, 320, 321, 372; D. Jones, M.D. Depo. at 156, Dist. Ct. Doc. No. 619. Obviously, if a dentist submits inflated fees to PBS, his usual charge will be inflated. Likewise, since customary charges are based on the "usual" charges calculated by PBS, the submission of inflated fees artificially increases PBS' customary charge allowance cap.

PBS' staff performs a variety of pre-treatment and post-treatment utilization review functions concerning services to its subscribers. One function particularly relevant to the instant issue is the in-office review (IOR). During the course of an IOR, PBS seeks to verify accuracy of

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[1] If unique or complex circumstances are involved in a particular situation, PBS may allow a charge in excess of the dentist's usual charge or the applicable customary charge. Such reasonability allowances are determined by PBS-employed dental advisors and are not at issue herein.

reporting and questions of over-utilization and mis-utilization of procedures. Also during an IOR, PBS seeks to verify the dentist's usual charge certifications to assure that the dentist has not charged inflated fees due to the presence of insurance coverage.[2]

PBS conducts IORs of both par and nonpar dentists in a uniform manner[3] and does not discriminate between par and nonpar dentists in selecting dentists to be reviewed or in acting upon its findings. IORs are conducted by members of PBS' staff.

If an IOR indicates a refund is due to PBS and if the dentist participates, PBS can collect the amount overpaid by offsetting against payments due to the dentist for other services. If the dentist is a nonpar, PBS cannot offset any amounts overpaid because nonpars do not receive direct payment from PBS. Since many dentists have vigorously resisted IORs it has not been uncommon for dentists to resign their participation status to thwart the conduct of an IOR or to effectively prevent PBS from recouping overpayments.[4]

From 1975 through the first half of 1982, PBS sought to verify the usual charges of 374 dentists by means of

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[2]PBS' subscriber agreements permit PBS to confirm all matters concerning covered care regardless of the participation status of the provider. Furthermore, PBS' Regulations for Participating Doctors permit PBS to examine par dentists' records. J.A. 320.

[3]The decision to conduct an IOR is made by PBS' staff. Such decision may result from subscriber complaints that a dentist's charge(s) increased when the subscriber first obtained PBS dental coverage. J.A. 1306-09.

[4]As described by the Third Circuit, Pet. App. 5a, there remains pending in the District Court PBS' Counterclaim against Petitioners which alleges, *inter alia*, a conspiracy in violation of Section 1 of the Sherman Act concerning deparcipation with PBS and impeding PBS' conduct of IORs.

IORs. During that period 32% of the dentists contacted refused to verify their usual charges and/or refused to permit PBS access to their offices. Of the dentists contacted who agreed to verify their usual charges, approximately one-half were found to have submitted inflated fees to PBS. J.A. 1351.

PBS' By-Laws provide that its business and affairs shall be managed by its Board of Directors and that one-half of its Board shall be lay persons. J.A. 1331. PBS' Board consists of 32 members: 16 lay persons and 16 doctors (only two of whom are dentists). Within PBS' corporate structure various standing committees of various composition exist to consider matters referred to them by the Board or management of PBS. The two committees at issue herein, the Dental Policy Committee and the Dental Review Committee, each have a majority of participating dentists as members. Committee members are appointed by the Chairman of PBS' Board in accordance with PBS' By-Laws. J.A. 1341-42. There is no basis for PDA's assertion that committee members are elected to represent "fellow par dentists".

III. REASONS FOR DENYING THE WRIT

1. The Issue Of Provider Control Presents A Question Of Fact Which Was Fully Analyzed And Correctly Decided By The Courts Below.

Each argument made by PDA in its Reasons For Granting the Writ assumes the existence of a factual predicate, i.e., provider control, contrary to the facts found by the courts below. Both the Third Circuit and the District Court specifically held that PDA presented no facts to support its horizontal conspiracy argument. Pet. App. 16a,

43a. Nonetheless, PDA mischaracterizes the Third Circuit's opinion as holding that "even where there is strong evidence that *de facto* control rests with the provider committees, the requirement of board ratification is sufficient to terminate any claim under section 1 of a conspiracy to restrain trade by injuring a competing group of providers." PDA Pet. 8.

The legal issue presented by PDA's Petition is a simple one and is clearly fact-bound: whether PBS' dental reimbursement system constitutes unilateral action or, instead, is the product of a conspiracy of par dentists who serve on certain PBS committees.[5] Chief Judge Aldisert's opinion clearly shows that the Third Circuit made a complete analysis of the committee actions at issue and correctly held that "(t)o give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself." Pet. App. 18a.[6]

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[5]The Federal Trade Commission recognizes that the ultimate issue of provider control "will be a question of fact in each particular case." Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981), 3 n.3 (1981).

[6]The Third Circuit noted that PDA's provider control argument "is dependent upon proof that participating dentists, through their majority membership on the two Blue Shield committees, actually controlled the establishment of the UCR system implemented by Blue Shield." Pet. App. 12a. Furthermore, the Third Circuit, after distinguishing the instant facts from those present in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), recognized that "(t)o the extent that Blue Shield's establishment of the UCR reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of § 1." Pet. App. 14a. However, contrary to PDA's assertions, the Third Circuit rejected PDA's provider control argument "*because the uncontroverted facts furnish no support for it.*" (Emphasis added.) Pet. App. 16a.

A. The Advisory Function of the Dental Policy Committee.

PDA's provider control argument about the Dental Policy Committee (DPC) is based on the undisputed fact that the DPC recommended to PBS' Board that PBS seek to allow at least 90% of aggregate charges submitted by all dentists. However, the undisputed facts surrounding the DPC's recommendation belie PDA's argument of delegation of pricing authority to the DPC. Moreover, there are no facts of record to support PDA's theory that the DPC was attempting to improve "the competitive position of pars *vis-a-vis* non-pars . . . by setting the differential at a figure large enough to create a significant incentive for patients to choose pars over non-pars" but not so large as to deprive pars of a profit for their services.[7] PDA Pet. 12.

PDA acknowledges that recommendations to an insurer by a group of providers concerning the insurer's treatment of competitors do not constitute a conspiracy with the insurer, PDA Pet. 14, and that technically the DPC "does not approve policies for the board, but merely makes recommendations to it." Pet. App. 16a. Furthermore, as noted by the Third Circuit, Pet. App. 17a, the DPC's recommendation that PBS seek "to allow at least 90% of aggregate charges" in the dental program was a goal "developed and urged by management." J.A. 1362. The minutes of the meeting of PBS' Board where it approved the DPC's recommendation as to allowing at least 90% of

[7]The minutes of the 1975 DPC meeting at issue clearly reflect that the DPC recommendation that a statewide geographic customary allowance charge class be retained in the dental program was management-inspired and premised on the lack of sufficient charge data to create additional valid geographic charge classes. The minutes do not mention participation status and no inference of a par dentist conspiracy can be reasonably drawn therefrom. J.A. 1280-84.

aggregate charges state that "this is the same position as taken by Management; the Dental Policy Committee is only agreeing to that position." Armitage Depo. Ex. 5 at p. 11, Dist. Ct. Doc. No. 898. No other evidence of DPC recommendations concerning payment allowances or treatment of dentists by participation status is cited by PDA in its Petition.

The Third Circuit's conclusion that the DPC's function was advisory only and was merely constituted and utilized as a resource to the Board is fully supported by uncontroverted facts of record.[8] In light of the lack of a par dentist majority on the Board (out of 32 directors, only two are dentists), the Third Circuit correctly concluded

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[8]Other adjustments to PBS' UCR system which had an effect on its dental program payout and which were neither recommended nor voted upon by the DPC include: (i) creation of an interim profile adjustment system which enables both pars and nonpars to obtain an interim update of "usual" charges if there had not been an increase in the prior two years, J.A. 1182-87; (ii) a change of the "usual" charge percentile from the 50th to the 75th percentile, which occurred in 1979, D. Jones, M.D. Depo. Ex. 14 at p. 348656-57, Dist. Ct. Doc. No. 619; R. Edmiston, M.D. Depo. Ex. 38 at p. 348557, Dist. Ct. Doc. No. 770; and (iii) use of charges reported in the first quarter of the current calendar year to determine "usual" charges, which occurred in 1981, J.A. 1210.

Furthermore, despite PDA's erroneous assertion, PDA Pet. 14-15, that the Board has "invariably" approved DPC recommendations, the uncontroverted facts prove otherwise. For example, nothing ever happened to the DPC's suggestion that the 90th percentile of a dentist's reported charges be used to calculate his "usual" charge for a specific procedure or that usual charges be updated every six months. J.A. 1282-84. Likewise, it is undisputed that the Board did *not* approve DPC's recommendation that payment be made for services to immediate family members under the dental program. Mann Depo. Ex. 36 at p. 13, Ex. 35 at p. 352281, Ex. 32 at p. 351821-351822, Dist. Ct. Doc. No. 736, and did *not* approve DPC's recommendation as to anesthesia coverage. Armitage Depo. Ex. 7, 16, 17, 18, Dist. Ct. Doc. No. 898.

that the 90% differential goal was not the product of a conspiracy of par dentists.

The Third Circuit's factual holding that PBS' Board, and not the DPC, controlled PBS' dental program and its holding that "[a]ction taken to find a market price so that a purchaser-insurer does not overpay does not constitute price-fixing", Pet. App. 17a, are consistent with traditional antitrust analysis and this Court's recognition in *Maricopa, supra,* that for an insurer to offer paid-in-full service benefit coverage someone must canvass providers "to determine what maximum prices would be high enough to attract sufficient numbers of individual doctors to sign up but low enough to make the insurance plan competitive." 457 U.S. at 353-54, n. 28. The facts that the 90% allowance goal was management-inspired and that the DPC only recommended the goal to PBS' Board show both the advisory nature of the recommendation and that such action was consistent with this Court's admonition in *Maricopa* that the insurer, and not the affected providers, should perform the canvassing.[9]

PDA quarrels with the Third Circuit's conclusion as to the DPC but offers no evidence, much less "strong" evidence, of *de facto* control by the DPC. Instead, PDA merely offers a conjectural theory unsupported by fact as to the asserted par dentist conspiracy. It is absolutely clear that the Third Circuit correctly determined the issue of DPC provider control and fully analyzed the DPC's role in rejecting PDA's par dentist conspiracy theory.

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[9]It should also be noted that PBS' UCR system does not involve any agreement by providers to charge a set fee, as was the case in *Maricopa*. The UCR system is based on providers' *personally determined charges* and the effect thereof is that a dentist is paid his personally determined, most frequently submitted charge for his services unless that charge exceeds the applicable customary level.

B. The Dental Review Committee And The Withholding Of Profile Updates Of Dentists Who Are Suspected Of Improperly Overcharging Blue Shield.

PDA's argument about the Dental Review Committee (DRC) consists of unsupported supposition and irrelevant references to "peer review" functions of professional societies. At issue is the authority of the DRC to prohibit profile updates of dentists who are reasonably suspected of improperly overcharging PBS by the submission of inflated charges because of the presence of insurance coverage. Although the DRC initially recommended such sanction, the record is clear that the authority to prohibit profile updates was not granted to the DRC, nor were profile updates withheld, until the authority was recommended by another PBS non-dentist committee and conferred upon the DRC by PBS' Board.[10]

As early as 1976, PBS' in-office review (IOR) experience had demonstrated that many dentists were charging their PBS subscriber patients higher rates than their non-insured patients. Such activity threatened the integrity of PBS' UCR system, which is predicated on the assumption that providers do not increase their fees because of the presence of insurance. By 1979 it was apparent that the magnitude of the problem could not be ascertained because PBS could not compel nonpars to verify their usual charges and because many pars resigned their par status to thwart PBS' verification process. Furthermore, it

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[10]Such fact clearly refutes PDA's assertion that it is an open question whether PBS' Board made an independent decision with respect to the DRC's profile update recommendation. (PDA Pet. 19).

was apparent that in many instances PBS could not recoup overpayments cost-effectively.[11]

The members of the DRC became aware of the inflated fee verification problem during DRC meetings.[12] In November, 1979 the DRC recommended that PBS consider withholding profile updates of dentists who refused to verify their usual charges and asked that the matter be referred to "the appropriate Committee of the Board of Directors for policy consideration." J.A. 1461. Ultimately, after the recommendation was approved by PBS' eleven member Professional Relations Committee (only one of whom was a dentist), J.A. 1316; D. Jones, M.D. Depo. Ex. 18, 19, Dist. Ct. Doc. No. 620, on May 2, 1980 PBS' Board authorized the DRC to prohibit the update of profiles of *dentists* who refuse to verify that their fees to PBS are the fees they usually charge to non-insured patients. H. Armitage, M.D. Depo. Ex. 14 at p. 348842, Dist. Ct. Doc. No. 898.

Contrary to PDA's erroneous suggestion, no profile updates were withheld by PBS until the Board authorized

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[11]From 1975 through the first half of 1982, PBS sought to verify the usual charges of 374 dentists by means of IORs. During that period, 119 (31.8%) of the dentists contacted refused to verify their usual charges and/or refused to permit PBS access to their offices, 121 (32.4%) of the dentists contacted agreed to the verification and inflated charge problems in their billing practices were found, and 134 (35.8%) of the dentists contacted agreed to the verification and no inflated charge problems were found. J.A. 1351. PBS' difficulty in recouping overpayments was caused by the facts that many par dentists resigned their status when presented with an IOR or refund request, many nonpar dentists refused IOR requests and PBS is unable to offset overpayments as to nonpar dentists.

[12]The result of each IOR conducted and the status of each IOR requested by PBS' staff are presented to the DRC. Furthermore, the ethics of the dental profession condemn the charging of inflated fees because of insurance coverage. J.A. 773-75, 718, 722.

such action. J.A. 1311-12, 1347. Furthermore, the authority granted to the DRC was limited to the specific situation where a dentist refused to verify his usual charges, rather than "whenever the committee deemed it appropriate", as erroneously represented by PDA. PDA Pet. 18-19. Following Board authorization, the DRC has consistently prohibited profile updates of dentists who refuse to verify their usual charges.[13]

Four undisputed facts surrounding the grant of authority to the DRC to prohibit profile updates convinced the Third Circuit, Pet. App. 17a, that the DRC did not participate in price-fixing and readily demonstrate that the DRC's activity does not create a factual issue as to § 1 Sherman Act concerted action: (i) PBS' requirement that dentists not inflate their charges to PBS is consistent with the ethics of the dental profession, J.A. 773-75, 718, 722; (ii) PBS' IOR experience showed that about one-half of the dentists who agreed to verification had charged inflated fees and that about one-third of the dentists contacted refused to verify their usual charges, J.A. 1354; (iii) the Pennsylvania Department of Health approved the concept of PBS verifying dentists' usual charges by means of IORs, J.A. 1320-22;[14] and (iv) profile updates were not withheld

[13]Through the end of 1982 only approximately 85 dentists had been denied profile updates and subsequent to their agreement to verify usual charges, profile updates have been granted to 15 out of the 85 dentists. All of such profile update denials have occurred because of a refusal to verify usual charges. Furthermore, PBS' withholding of profile updates does not "freeze the fees" of the affected dentists but merely affects PBS' payment allowance. J.A. 1317-18, 1584.

[14]PDA erroneously suggests that the Third Circuit's holding as to the DRC is based in part on "state action" grounds. PDA Pet. 21. However, state approval of PBS' efforts to assure that its payments for dental services do not exceed its contractual obligations undercuts PDA's specious argument that denial of profile updates was motivated

(Continued on next page)

until both a non-dentist committee and PBS' Board authorized such action. J.A. 1311-12, 1347. In light of the foregoing, there is no basis for an inference that action taken to preclude fraudulent billing practices, which inures to the benefit of PBS (and therefore ultimately to its consumers) and which was authorized by PBS' Board demonstrates either provider control or price fixing.

The undisputed facts also belie PDA's transparent assertions as to the possible competitive consequences of DRC's denial of profile updates. The sanction has not been imposed because the DRC believes any dentist's fees are too high, as was alleged in *Ratino v. Medical Service of D.C.*, 718 F.2d 1260 (4th Cir. 1983) or too low, but is imposed only if a dentist refuses to substantiate that he has not been improperly overcharging PBS. Any dentist who is being denied a profile update can obtain one simply by substantiating his usual charges. Furthermore, contrary to PDA's assertions, there is no evidence of record that any dentist who has been denied a profile update competes with any member, past or present, of the DRC.

Likewise, the fact that profile updates have been denied to both par and nonpar dentists, J.A. 769-70, renders nugatory PDA's theory that the alleged conspiracy is one of par dentists to obtain a competitive advantage over nonpar dentists. Similarly, the fact that authority to deny profile updates only concerned dentists and that corresponding authority to prohibit profile updates of physicians was not granted to PBS' Medical Review Committee

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(Continued)
by a desire to confer a competitive advantage on any category of dentists.

militates against PDA's vague reference to an overall participating provider conspiracy against nonparticipating providers.[15]

Finally, PDA's assertion that the Third Circuit's analysis of the DRC would undermine any criterion proposed by the FTC to ensure that anticompetitive risks do not arise in peer review activities is irrelevant to the instant issue. The DRC's activities constitute "peer review" in only the broadest sense of the term and are inapposite to the peer review functions addressed by the FTC in its advisory opinions cited by PDA. The DRC does not address the reasonableness of any dentist's fee, nor is the sanction of denial of profile updates imposed because any fee or fees are considered to be too high or too low. Furthermore, the DRC only considers matters concerning a dentist's relations with PBS. J.A. 1335-38.

The orderly corporate process by which PBS' Board authorized the DRC to deny profile updates clearly shows that the DRC's authorization is not the product of a conspiracy of par dentists. The fact that the DRC's power is limited to the specific situation where a dentist refuses to substantiate that he is not improperly overcharging PBS demonstrates the legitimacy of the sanction. The sanction imposed only affects what PBS will pay for services, not what any dentist may charge. Therefore, the Third Circuit correctly held that the DRC has not "engaged in conduct that runs afoul of the antitrust laws." PDA App. 18a.

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[15]Corresponding power was not granted to PBS' Medical Review Committee because the problem of usual charge verification appeared to be limited to the dental area. J.A. 1236.

2. The Decision of the Third Circuit is Consistent with the Decisions of this Court and of the Circuit Courts of Appeals.

PDA's Petition alleges the existence of a conspiracy of par dentists to effect and enforce a 10% differential between aggregate charges submitted in PBS' dental program and PBS' aggregate payment for dental services.[16] The conspiracy is unsupported by the facts of record. Moreover, analysis of PDA's illusory assertions of the anticompetitive effects that are "very likely" to be caused thereby demonstrates that the Third Circuit's decision does not conflict with any decision of this Court or of any federal court of appeals.

PDA's argument that the cap on the UCR allowance may injure PBS by causing subscribers who are loyal to nonpars to switch dental insurers, PDA Pet. 13 n. 14, presents a practical impossibility because, as PDA acknowledges, PBS only markets *group* dental coverage

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[16]PDA vaguely suggests two other possible conspiracy theories: (i) a conspiracy of DRC members to obtain a competitive advantage over those few dentists who have been denied profile updates because they refuse to substantiate that they are not improperly overcharging PBS because of the presence of insurance coverage, PDA Pet. 19-20, and (ii) an overall conspiracy of all participating providers. The DRC theory fails because there is no proof of a competitive relationship between any DRC member and any dentist denied a profile update and by the circumstances surrounding profile update denials. The overall participating provider theory is an obvious afterthought. The PDA did not raise such a conspiracy theory before the Third Circuit and the Third Circuit did not address it. For this reason alone this Court should decline to address it. *Monsanto Co. v. Spray-Rite Service Corp.*, ____ U.S. ____, 104 S.Ct. 1464, 1468-69, n.6 (1984). In any event, there is no evidence of record of such a conspiracy and there is no dispute that during the time period in question (1975) PBS was compelled by state statute to have a provider majority on its Board. Act of Nov. 15, 1972, P.L. 1063, No. 271, § 6328, formerly codified at 40 P.S. § 6328.

and individual subscribers lack the prerogative of choosing a dental insurer. Likewise, PDA's assertion that if PBS paid 100% of dentists' charges, patients would have no incentive to choose pars over nonpars directly contradicts PDA's repeated assertions in the courts below that PBS' policy of making direct payment to only pars causes PBS subscribers to boycott nonpar dentists. PDA Reply Brief to Third Circuit, 16, 17; PDA Brief to Third Circuit 38-40; PDA Brief in Opposition to Summary Judgment 17, 72.

The undisputed fact that the DRC's denial of profile updates affects both pars and nonpars directly contradicts PDA's explanation of the DRC's role in its par dentist conspiracy theory as "improving the competitive position of par dentists." PDA Pet. 19.

When PDA's illusory conspiracy assertions are compared to the undisputed facts of record it is clear that the courts below correctly determined that PDA's par dentist conspiracy theory is purely speculative and without factual support.[17] Furthermore, it is clear that the true nature of PDA's complaints is about the pro-competitive pressures presented by PBS' dental program. As noted by PDA, PDA Pet. 7-8, the FTC has conducted investigations of the question of physician (not dentist) control of Blue Shield plans which culminated in staff reports recommending industry-wide rulemaking by the FTC. However, the FTC rejected the need for industry-wide rulemaking, *see* Advance Notice of Proposed Rulemaking, 45 Fed. Reg. 17,019, 17,022-23 n.2 (1980), and instead determined to approach

[17] It should be noted that, as found by the District Court: "it is not testimonial evidence that PDA relies upon to establish and advance its 'conspiracy mechanism' argument. PDA does not point to conspiratorial conversations, the testimony of Blue Shield insiders or participating dentists to establish its conspiracy theory." Pet. App. 40a-41a.

the issue on a case-by-case basis to avoid discouraging pro-competitive prepayment programs. Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981), p. 3-4.

To paraphrase the Seventh Circuit's opinion in *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195, at 1206 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982), the gravamen of PDA's complaint is PBS' refusal to pay more than a competitive price for dental services. The pro-competitive aspects of a Blue Shield or Blue Cross plan computing its reimbursement allowance based upon the prevailing competitive price in the marketplace have been recognized by numerous courts. *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2d Cir. 1982); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

There is no dispute that PBS' UCR dental program creates an incentive for subscribers to patronize par dentists and that all Pennsylvania dentists are free to participate with PBS. Therefore, if a nonpar dentist refuses to meet the price competition created by PBS and thereby loses patients, whatever injury he suffers is not cognizable under the antitrust laws because the injury results from increased rather than reduced competition. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977); *Travelers Ins. Co., supra.; Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir.), *cert. denied*, ____ U.S. ____, 104 S.Ct. 88 (1983). Likewise, dentists, par or nonpar, who

receive less for services to PBS subscribers than they do from their non-insured patients do not suffer antitrust injury. *Medical Arts Pharmacy, supra,* 675 F.2d at 507 ("A low profit margin on sales to Blue Cross subscribers could not, however, establish an antitrust violation under the rule of reason."); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230, 235 (N.D.Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir.), *cert. denied,* 459 U.S. 1016 (1982) ("The failure to make more money . . . is simply not the kind of problem which the antitrust laws address.").

It is clear that the courts below did not ignore this Court's cautionary language about use of summary procedures in antitrust litigation in *Poller v. Columbia Broadcasting System, Inc.,* 368 U.S. 464, at 473 (1962)[18] and that the Third Circuit's decision does not conflict with the decisions of any federal court of appeals.

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[18]Although antitrust attacks on contracts between insurers and providers have intensified in recent years, numerous courts have upheld the legality of such provider agreements on motions for summary judgment. *Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau,* 701 F.2d 1276 (9th Cir.) *cert. denied,* _____ U.S. _____, 104 S.Ct. 88 (1983); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D.Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir.), *cert. denied,* 459 U.S. 1016 (1982); *Quality Auto Body, Inc. v. Allstate Insurance Co.,* 660 F.2d 1195 (7th Cir. 1981), *cert. denied,* 455 U.S. 1020 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 518 F.Supp. 1100 (D.Conn. 1981), *aff'd,* 675 F.2d 502 (2d Cir. 1982); *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia,* 498 F.Supp. 63 (E.D.Va. 1980); *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cases ¶ 63,351 (E.D.Mich. 1980); *Davidowitz v. San Diego County Dental Society,* 1983-1 Trade Cases ¶ 65,231 (S.D.Cal. 1983), *denying reconsideration,* 1984-1 Trade Cases ¶ 65,988 (S.D.Cal. 1984).

These cases indicate a judicial consensus that antitrust challenges to provider agreements do not ordinarily present genuine issues of material fact which would preclude a grant of summary judgment.

The foregoing discussion of the pro-competitive effects of PBS' dental program dispels any notion that the Third Circuit failed to analyze PDA's complaints under the rule of reason. Furthermore, PDA's references to *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981); *Glen Eden Hospital, Inc. v. Blue Cross and Blue Shield of Michigan, Inc.*, 740 F.2d 423 (6th Cir. 1984); *St. Bernard General Hospital v. Hospital Service Association of New Orleans, Inc.*, 712 F.2d 978 (5th Cir. 1983), *cert. denied*, ____ U.S. ____, 104 S.Ct. 2342 (1984); and *Ratino v. Medical Service of D.C.*, 718 F.2d 1260 (4th Cir. 1983) do not demonstrate a split in circuits on the provider control issue because those cases are both legally and factually distinguishable from the instant case.

The PDA Petition does not allege a conspiracy by one discipline of provider to preclude another discipline from obtaining reimbursement from an insurer, as was presented in *Virginia Academy*. Furthermore, *Virginia Academy* is also distinguishable because therein provider control was based on board composition plus abundant other evidence.[19]

St. Bernard Hospital and *Glen Eden* are also clearly distinguishable because in both cases the alleged conspiracies consisted of participating providers causing insurers to reimburse all non-participating providers at lesser rates. In the instant case the conspiracy alleged by PDA is one to lower PBS' payment allowance to both par and nonpar

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[19] *Virginia Academy* should be contrasted with *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F.Supp. 63 (E.D.Va. 1980) wherein the court applied the Fourth Circuit's "walking conspiracy" theory and found no provider control because the insurer's board did not consist of a provider majority and *no direct evidence* of provider control of the insurer by other means was presented.

dentists. In *St. Bernard Hospital,* representatives of participating hospitals comprised a super-majority of the insurer's board of directors as distinguished from the instant case where only two members of PBS' 32-member board are dentists. *Glen Eden* is also further distinguishable, as recognized by the Third Circuit, Pet. App. 15a, because the plaintiff was allowed only severely limited discovery on the provider control issue.

Ratino is similarly distinguishable because the Fourth Circuit merely reversed the district court's grant of summary judgment on the, by then, eroded grounds of the McCarran-Ferguson Act business of insurance exemption. Moreover, PDA's reference to *Ratino's* discussion of the peer review function is factually inapposite because in *Ratino* a binding peer review determination of the reasonableness of an individual doctor's fees was at issue.

In the final analysis, PDA seeks this Court's review of the factual determination of two fact finders which both reached the same conclusion that PDA's provider control conspiracy argument is without factual support. There is no reason for this Court to review the fact-bound decision of the Third Circuit. PDA's Petition is without merit and it is clear that PDA is merely seeking, in the words of the District Court, "the opportunity . . . to pursue their case in search of its existence." Pet. App. 56a.

IV. CONCLUSION

The Petition For A Writ of Certiorari should be denied.

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Dated: March 14, 1985

RULE 28.1 CERTIFICATE

Respondent Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield respectfully advises the Court pursuant to Rule 28.1 of the Rules of this Court that it has no parent and that it owns stock in the following subsidiaries (except wholly-owned subsidiaries) or affiliates: Camp Hill Insurance Company.

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ALEXANDER L. STEVAS,
CLERK

No. 84-1296

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; and THOMAS L. PERKINS, D.M.D.,

Petitioners,

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD, and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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IN THE

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REPLY BRIEF FOR PETITIONERS

As we argued in our petition, this case squarely presents the issue whether Blue Shield plans around the country, having cleansed their boards of majority provider representation, can continue to operate *in practice* through committees that represent the interests of particular groups of providers. The Third Circuit is on record favor-

ing the view that board ratification of committee decisions, no matter how meaningless in practice, is sufficient to end the antitrust analysis. This position is indefensible. It would allow, for example, a situation where several providers, elected by many other competing providers, join together on a committee and draw up a schedule of fees which is then rubber-stamped by the Blue Shield Board. Moreover, this position of the Third Circuit is very hard to square with the more realistic approach to assessing provider control adopted in such cases as *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), and *Glen Eden Hospital, Inc. v. Blue Cross and Blue Shield*, 740 F.2d 423 (6th Cir. 1984).[1]

Respondents, in their opposition brief, do not seriously contest the importance of the legal issues raised in the petition for review. Instead, they take the position that the decision below was based purely on factual analysis, implying that the Third Circuit did not squarely reject petitioners' legal theory. The reality is far different. It is true that the decision of the Third Circuit sounds at times more like that of a "fact finder," Resp. Br. at 21, than like that of an appellate court reviewing a grant of summary judgment. Nevertheless, it is clear that the Third Circuit ruled directly on the key legal issue in this case, involving the elements required to show a Sherman Act conspiracy. Review of that legal ruling is therefore fully appropriate at this time.

The central contention by petitioners below was that, despite the formal mechanism of a "neutral" Blue Shield Board, the Dental Policy and Dental Review Committees had *de facto* control over key issues affecting competition

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[1] Respondents' effort to distinguish the substantive antitrust violations in these two cases, Br. at 20-21, misses the point. The crucial point is that the courts in these two cases called for a much more searching inquiry into provider control than did the Third Circuit here.

in the market for dental services. Because most of the members of these committees are "participating" dentists ("pars"), the delegation to them of effective control over the terms of competition with non-pars constitutes an illegal conspiracy under section 1 of the Sherman Act.

In rejecting this contention, the Third Circuit held, in essence, that *de facto* control is not enough. After summarizing petitioners' claims with respect to the committees, it commented that "majority membership on a committee, without more, does not make a prima facie case of structural horizontal conspiracy." Pet. App. 16a. Startting from this indisputable premise, the court proceeded to "analyze" the "power and . . . authority" of the committees. *Ibid.* But this analysis was based almost entirely on the *formal* structure of Blue Shield. Terming the committees "advisory only," *ibid.*, the court concluded that the Board remained the sole "decisionmaker," *id.* at 18a. It then made clear its reliance on the fact of purely formal Board control by dismissing the issue of *de facto* control in a single sentence: "We are not impressed by appellants' specific contentions in this regard, *including its emphasis on the statement of one Blue Shield official that he could not remember any occasion when the policy committee's recommendation was not accepted by the board.*" *Id.* at 16a-17a. (emphasis added)

As we have noted, respondents do not greatly concern themselves with defending the legal merits of this decision.[2] Instead, they suggest that the Third Circuit made

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[2] Respondents do make a few unavailing arguments on the legal merits. First, they argue that there could be no conflict of interest between Blue Shield and the provider members of the Policy Committee. Br. at 16-17. The suggestion is that, no matter what cap is imposed on Blue Shield payments, there will be no loss by Blue Shield of those subscribers who are loyal to non-par dentists and unwilling to pay the larger difference between the allowances and their dentists' fees. This suggestion is clearly wrong. Individual subscribers may, as respondents argue, be unable to choose a new

quite a different ruling. The bulk of their brief represents an effort to recast the decision below as one rejecting the *de facto* control argument *on the facts*. See Br. at 6-7 & n.6, 21. While respondents are aided in this effort by some ill-advised (and inaccurate) discussion of the facts in the Third Circuit opinion, it remains true that the court did not, and could not on summary judgment, rely on some "finding" about whether the committees effectively controlled Blue Shield policy. Instead, its decision clearly stands for the proposition that *de facto* committee control is not enough.

In their efforts to rewrite the decision below, respondents combine several strategems. First, as to the Dental Policy Committee, they attach great significance to the Third Circuit's characterization of the committee as formally "advisory," Br. at 7-10, as if that terminology were somehow inconsistent with a finding of *de facto* control. They then rely on a factual assertion in the decision below which is simply false—the statement that the "goal of seeking to allow at least 90 percent of aggregate charges" was "developed and urged," not by the Dental Policy Committee, but by "management." Pet. App. 17a, quoted in Br. at 8. In fact, as we have discussed, Pet. at 14 n.16, the minutes of the committee plainly reflect that this recommendation came *from* the committee. JA. 1280-1284.[3] Moreover, when Dr. Callahan, a member of the

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group health plan, but pressures from subscribers may well lead *employers* to choose different health plans.

Similarly, respondents argue that the new performance allowance was actually "pro-competitive." Br. at 17-19. But that would only be true if the allowance were set with the interests of *Blue Shield* in mind. Where, however, a group of par dentists are able to influence the amounts paid by Blue Shield to serve their *own* interests at the expense of non-pars, the arrangement is plainly anti-competitive.

[3] We note that respondents, in their footnote on this issue, claim only that management initiated the decision to retain statewide

committee since its inception, was asked whether the committee's recommendations were "in any way molded or shaped by the staff persons who attend those meetings," he answered: "No way, underlined fourteen times." J.A. 3211.

Beyond that, respondents simply offer their own highly controverted factual claims about *de facto* control, which they seek attribute to the Third Circuit. For example, they argue that the Board does not always defer to the Dental Policy Committee. Br. at 9 n.8. But as the Third Circuit itself noted, Pet. App. 16a-17a, petitioners submitted the testimony of the current chairman of the Board of Blue Shield and a long-standing member of the Board, who said he could not "think of a single instance" in which the Board disapproved a committee "recommendation." [4] J.A. 3219. This key issue therefore is certainly "disputed," to say the least.

Similarly, respondents argue that there is no evidence in the record showing that, in setting the performance level, the Policy Committee was seeking to benefit pars at the expense of non-pars. But there is ample evidence of such a motive. First of all, contrary to respondents' contention, Br. at 6, it is quite clear that the committee members *are* the elected representatives of par dentists.[5] Moreover the committee members necessarily knew that, in lowering the performance level, they would be reducing Blue Shield payments and thus increasing the amounts

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charge classes. Br. at 8, n.7. They do not themselves find any evidence in the minutes of management initiation of the 90 percent performance level.

[4] The District Court itself acknowledged that there was "circumstantial evidence" of *de facto* control. Pet. App. 40a n.12.

[5] Each year the pars in each of ten districts elect several "corporate members" to represent them at the annual meeting of Blue Shield. Out of this group, the chairman of Blue Shield selects the members of both the Dental Policy and Dental Review Committees. J.A. 2716-2718.

that non-pars would have to collect directly from their patients. See J.A. 3255-57, 3294-95, 3347-48. This would obviously give patients an increased incentive to go to par dentists.

As for the Dental Review Committee, respondents do not dispute the fact that the committee has unreviewable authority to "freeze" the profiles of competing dentists, or that this authority stems from a proposal made by the committee itself. It is this structure—delegation of such a key "peer review" power to a committee of competitors —that creates the antitrust problem.

Respondents, however, point to the fact of Board approval of the policy, and suggest that this disposes of the issue of *de facto* control. Br. at 12-13. Here again, nothing in the decision below indicates any interest in determining who had actual control. The emphasis is on *formal* Board approval of the policy—a fact we do not dispute but which, in our view, does not immunize an otherwise illegal conspiracy.

Respondents supplement this argument by asserting that the profile "freezes" are automatic and, in any event, inure to the benefit of Blue Shield. Br. at 13-15. But respondents do not explain why it is necessary that power be given to a provider-dominated committee, with all the attendant dangers that such a structure creates.

At minimum, petitioners deserve a chance to prove that both provider-dominated committees exercised sufficient control over Blue Shield's decisions to constitute an illegal conspiracy. This chance was cut off when the Third Circuit held that no amount of actual control can negate the fact of Board ratification of committee actions. Such a ruling will have far-reaching effects as Blue Shield plans proceed to work out new modes of operation under the nominal supervision of "neutral" Boards of Directors. It requires review by this Court.

CONCLUSION

For these reasons, the petition for a writ of certiorari should be granted.

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